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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Legal Protections Against Child Abuse 42
Monrad G. Paulsen

Improving an Institution's Services for the Retarded . 49
Owen E. Franklin and Donald J. Baker

Services for Children With Multiple Handicaps . . . 55
John C. MacQueen

The Genetic Basis of Some Abnormalities in Children . 60
Ellen S. Kang

Training Nonprofessionals for a Child Welfare Service 63
Lela B. Costin

Selecting Foster Parents for Disturbed Children . . . 69
Anthony N. Maluccio

Family and Child Welfare in South Vietnam 75
Elisabeth Shirley Enochs

here and there 78

in the journals 81

book notes 83

readers' exchange 84

The wonder and tenderness in this boy's face are a reminder of children's enormous capacity to spread their love in many directions. But a child's capacity to love at all, if not the child's life itself, may be in danger of annihilation if he is the subject of abuse by adults. What States are doing to protect children from abuse is discussed in the lead article in this issue.

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In recent years, reports of shocking instances of child abuse in court records, professional literature, and the daily press have prompted an outraged public to demand that "something be done." Many States have responded with constructive measures to provide greater protection for children. Sometimes, however, the pressure has been for additional punitive laws, with little attention to the broader legal framework required for effective child protection. It seems pertinent, therefore, to review the general legal framework in which the problem of child abuse is being dealt with in this country and some of the legal and social issues involved.

In the United States, raising children is the business of parents, not of government. Hence, the law normally gives the custody of children to parents, counting on parental love to call forth the care and protection a child requires. The law in every State, however, has provided for intervention by society when parental care is dangerously faulty or insufficient.

Four sets of legal provisions are directly related to child abuse:

1. Provisions of the criminal law, which can be invoked to punish persons who have inflicted harm upon children.

2. Juvenile court acts, which universally provide that when there is evidence of abuse parents or other caretakers may be found to have "neglected" a child; and that in such instances the court may institute protective supervision of the child or order his removal from the home.

3. Legislation, in many States, authorizing or es-

LEGAL PROTECTIONS

AGAINST CHILD ABUSE

MONRAD G. PAULSEN

tablishing "protective services" for abused and neglected children as a part of a comprehensive program of public child welfare services.

4. Child abuse reporting laws, now existing in almost every State, which encourage the reporting of suspected child abuse so that the other provisions for the protection of children can be called into play.

The criminal law

The child abuse problem does not require new criminal legislation though legislatures are often led to forget that fact by sensational cases. Murder, mayhem, assault, and battery, even when committed by parents, are punishable crimes in every State criminal code. Furthermore, existing criminal laws expressly forbid "cruelty to children" in those very words or in a similar phrase. However, State legislatures often forget these facts when the public, stirred up by newspaper reports of sensational cases demands new, but unnecessary, punitive laws.

In any event, criminal sanctions are a poor means of preventing child abuse. Day-to-day family life, charged with the most intimate emotions, is not likely to be an area of life easily ruled by the threat of fines or imprisonment. A criminal proceeding may punish an offender who deserves punishment but it may also divide rather than unite a family. The criminal law can destroy a child's family relationships; it cannot preserve or rebuild them. The most severe cases of child abuse may call for prosecution, but the prosecutors are not able to arrange for the care a child needs.

A criminal prosecution is a clumsy affair. The proceedings take a great deal of time—for the prosecutor to prepare his case, for postponements to serve the convenience of the defense, the judge, or the witnesses. Guilt must be established beyond a reasonable doubt. Convictions are not easy to obtain because guilt is hard to prove, particularly in child abuse cases since the abuse usually takes place in the absence of witnesses who will testify.

The beginning of a prosecution is likely to be the end of a chance to improve a child's home situation. Parents are nearly always resentful of the proceeding. The hostility engendered makes casework with the child's family all but impossible if the offending parent is still in the home.

All in all, criminal sanctions can do little to help a child. The major problems concern his care and custody.

The juvenile court

In every State, statutory provisions give juvenile courts power over "neglected" children. And in every State, irrespective of the particular legislative language of the juvenile court act, a parent's physical mistreatment of a child is legally a form of "neglect." The neglect provisions, however, vary. Some of the States focus on the behavior of the caretaker: a neglected child is one whose parents "subjected him to cruelty or depravity." Other States stress the child's surroundings: "A neglected child is one who is not provided with a home or suitable place of abode, or

Based on a study conducted by the author with the support of a research grant from the Children's Bureau. A full report of the project is in preparation.

whose home is unfit for him by reason of neglect, cruelty or depravity of either of his parents. . . ." Some States simply draw attention to the child himself: A neglected child is one "who is subject to cruel and inhuman treatment and shows the effect of being physically mistreated."

The differences in statutory language are important. The words tell us precisely what evidence is necessary to make out a case of neglect. In States which define neglect in terms of the misconduct of parents, a neglect case can be proved only by adducing evidence of parental involvement. In these States neglect adjudications are not possible in some cases because the injuries cannot be tied to the conduct of the parents, even though juvenile courts in most States only require proof by a preponderance of the evidence, not proof beyond a reasonable doubt. Even in the States requiring only a preponderance of evidence, this must be forthcoming. Situations about which objective items of proof cannot be produced, cannot be remedied in court.

In many cases, however, the judges are overly timid in how they view the evidence. Adjudications of neglect can properly rest on circumstantial evidence. Inferences of parental fault can properly be drawn, for example, from (1) the young age of the victim, (2) the number and nature of the injuries, (3) the place where they were incurred, (4) unconvincing parental explanations, and (5) the fact that the parents were the injured child's custodians and hence in proximity to him most of the time. Not every legal remedy need rest on the testimony of an eyewitness.

A recent opinion of Judge Harold A. Felix of the Family Court of the State of New York is especially significant because he permitted circumstantial evidence to put a burden of "satisfactory explanation" on the child's parents. Denying a motion to dismiss a neglect petition, Judge Felix wrote that the:

> . . . proceeding . . . was initiated undoubtedly by a consensus of view, medical and social agency, that the child Freddie, only a month old, presented a case of a battered child syndrome. Proof of abuse by a parent or parents is difficult because such actions ordinarily occur in the privacy of the home without outside witnesses. Objective study of the problem of the battered child which has become an increasingly critical one has pointed up a number of propositions, among them, that usually it is only one child in the family who is the victim; that parents tend to protect each other and resist outside inquiry and interference; and that the adult who has injured a child tends to repeat such action and suffers no remorse for his conduct.
>
> Therefore in this type of proceedings affecting a battered child syndrome, I am borrowing from the evidentiary law of negligency the principle of "res ipsa loquitur" and accepting the proposition that the condition of the child speaks for itself, thus permitting an inference of neglect to be drawn from proof of the child's age and condition, and that the latter is such as in the ordinary course of things does not happen if the parent who has the responsibility and control of an infant is protective and nonabusive. And without satisfactory explanation I would be constrained to make a finding of fact of neglect on the part of a parent or parents and thus afford the court the opportunity to inquiry [sic] into any mental, physical, or emotional inadequacies of the parents and/or to enlist any guidance or counseling the parents might need. This is the Court's responsibility to the child.[1]

Statutes which define neglect in terms of a child's environment do not present the same difficulty of proof as do those which address themselves to the parents' conduct. The fact that several injuries have occurred under inadequately explained circumstances can suffice to show that a child's "environment is injurious to his welfare." [2]

Juvenile court judges have a wide range of powers designed to give the highest practicable degree of flexibility in making dispositional decisions. A judge may warn parents or counsel them. He may order medical or psychiatric treatment for the child or the parents. He may place the child under protective supervision in his own home. He may remove the child from his parents should that extreme step be necessary. The judge also has ample power to act quickly in emergencies; but, unfortunately, a fast judicial response to emergencies may not, in fact, take place because a juvenile court judge may not be readily available.

Another important point is the leeway provided by this wide range of powers. Proof of neglect really involves answering two questions: (1) What really happened? (2) Are the "facts" to be characterized as "neglect"? What a judge is likely to characterize as "neglect" will, I believe, depend upon the action which he feels called upon to take.

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The point to be grasped in Judge Felix's opinion is that he was not contemplating removal of the infant when he entered his judgment. Juvenile court judges surely are affected by a sense that the action taken by the court order must be related to the seriousness of parental unfitness as demonstrated by the evidence.[3] A severe spanking by a mother, harassed by the problems of everyday living, might sustain a neglect adjudication if the court were to make the adjudication to expedite further inquiry or to supply social services through the probation staff. It would hardly sustain the judgment if the court were to take the child away from home for any but the briefest period.

Protective supervision

The full use of juvenile court powers can keep a child in his home and still offer protection by providing official intervention into family life. The Children's Bureau has warned that protective supervision "should not be allowed to degenerate into mere watchfulness" but should be "a purposeful activity directed toward the improvement of the child's situation through the use of established casework techniques and the utilization of other community resources."[4]

However, we should not forget that many families will resent such official intervention. Court ordered protective supervision contains an important element of authority. Therefore, orders of protective supervision, should be periodically reviewed by the juvenile court with a view to termination if the intervention is no longer necessary. Indeed, the New York Family Court Act limits the duration of an order of supervision in a neglect case to a period of 1 year unless "the court finds at the conclusion of that period that exceptional circumstances require an extension thereof for an additional year."[5]

The problem of the juvenile court judges in abuse cases, of course, is to balance the interests of the parents against the likelihood of new harm to the child. No task is more difficult than predicting the recurrence of behavior which can endanger a child. The "balancing of interests" is made more difficult for a judge who is considering whether to take a child from his parents when under the evidence the degree of parental involvement in the child's injury is not perfectly clear.

Nevertheless, leaving in his home a child who bears the marks of unusual injuries which seem to have been intentionally inflicted is taking a chance with a child's life. Not all doubts should be resolved in favor of parents. Those who seek a court order to remove a child from a dangerous situation should not have to disprove every plausible explanation for the child's wounds. Temporary removal is not the same as a permanent change of custody. Parents who accept and profit by protective intervention can and do regain custody of their children when new evidence suggests that they are able to care for them properly. Parents have a right to their children, but their children have a right to live.

Protective services

In many States, the law has provided for "protective services" as a part of public programs of comprehensive child welfare services. In addition, some States have granted charters to voluntary agencies to carry out protective services.

Protective services aim at effecting constructive change within the family in which there has been child neglect or abuse so that the child's environment may be improved. A key point is that the offer of services is made as a result of a complaint or referral from someone in the community and not usually at the request of one or both of the child's parents. Some of the parents most in need of assistance would never seek such help voluntarily.

Child protective services are offered without a court order although they may, in some instances, be identical with the services provided in protective supervision ordered by the court.

The Children's Bureau has proposed that a State or local welfare department be required to:

> **Investigate complaints of neglect, abuse, or abandonment of children and youth by parents, guardians, custodians, or persons serving in loco parentis; and on the basis of the findings of such investigation, offer social services to such parents, guardians, custodians, or persons serving in loco parentis in relation to the problem, or bring the situation to the attention of a law enforcement agency, an appropriate court, or another community agency.[6]**

Thus, under proper child protective legislation, a welfare department would be *required* to "investigate" and to "offer social services" to families in cases of alleged child abuse. But the duty does not stop there. The offer of service may be refused. If so, the welfare department can "bring the situation to the attention" of others, including a juvenile court.

In some States, the laws require that protective services be established; in others, the services are merely authorized, leaving the final decision to local

units of government. In any case, if the public welfare agency is to provide protective services to investigate complaints and serve abused and neglected children, the legislature must not only mandate or authorize these services but must also provide appropriations to make them a reality.

The "reaching out" with protective services, whether by a public welfare department or a voluntary agency, presents a problem which the good motives of the agency ought not to obscure. If help is offered when it is not wanted, the offer may contain an element of coercion. There is a danger of overreaching when the agency deals with the most vulnerable members of the community who may easily be cowed by apparent authority. The extent to which the offering of protective services should be reviewed by some judicial or administrative agency is beyond the scope of this paper. Here it is appropriate merely to note the problem. The privacy of a family ought not to be upset lightly.

Reporting laws

Whatever protection the criminal law, the juvenile court, or child protective services can offer to children, it can be offered only in respect to known instances of abuse or neglect. Therefore, statutes which encourage the reporting of suspected cases are an integral part of the law's attempt to protect children.

Bringing suspected cases to the attention of community authorities has been inhibited by many factors. Children, generally, cannot or do not speak out. Neighbors and friends hesitate to make accusations. An abusive father or mother, facile with explanations, often escapes discovery because of the common assumption, "certainly these respectable people couldn't do such a terrible thing to their children."

Over the years, many physicians have failed to alert the community's resources for child protection to suspected cases of abuse. For a number of special reasons they have kept their suspicions to themselves, treated the child for his injuries, and sent him home despite the possibility of repeated abuse. Some physicians have not reported such cases because of fear of civil or criminal liability. Others have been reluctant to play the role of "officious intermeddler," particularly when they might have to face angry parents. Some have regarded reporting as a breach of the special confidential relationship between physician and patient. Some have not reported because they did not know to whom to report and had no reason to believe that it would benefit the child.

In 1963, the Children's Bureau and The American Humane Association published model legislative language [7] and guidelines,[8] respectively, to assist States in drafting laws which would encourage physicians to report cases of suspected child abuse. In 1965, the Council of State Governments also published a statutory model for child abuse legislation.[9]

The theory behind these legislative suggestions is simple: Physicians possess the expert skill and judgment for recognizing a case of possible child abuse, a first necessity for bringing an abused child to the attention of the community's legal and social welfare resources. They regularly see cases of injured children and, in some instances, come to suspect that the injuries have not been incurred in the manner described by the caretakers. Therefore, physicians should report their suspicions so that the cases can be investigated and appropriate measures taken for the children's protection. The model laws would require physicians to report cases in which abuse is suspected, and free them from civil and criminal liability for doing so, and from any legal prohibition against testifying about the case in court.

Few legislative proposals in the history of the United States have been so widely adopted in so little time. During the past 3 years, 47 States passed statutes aimed at increasing the reporting of child abuse cases. At the beginning of 1966, only Hawaii, Mississippi, Virginia, and the District of Columbia were without such laws. This remarkable record has been achieved largely as a result of the publication of the proposals of the Children's Bureau and The American Humane Association, and of the wide publicity given the problem of child abuse in the medical and social work literature as well as in the mass media, including a drama in the "Ben Casey" TV series.

The proposals for reporting laws present a number of legislative issues, and as the 47 legislatures have tried to resolve them they have produced statutes with a great many differences.

All the State laws protect physicians against liability for reporting, although in Wisconsin legal immunity is provided only from criminal liability. In the six States where the statutes do not impose a duty to report, the extension of legal immunity is the only effect of the law aside from whatever encouragement to reporting may come from the passage of the legislation and the inclusion of the reporting scheme in the statute books. The statutes in these six States

and a 1965 proposed statute drafted by the Office of the General Counsel of the American Medical Association [10] reflect a view held by some physicians that, for professional reasons, doctors should be allowed to retain some discretion in reporting. Other physicians, the American Academy of Pediatrics, and 41 State statutes support mandatory reporting.

A mandatory requirement for reporting can be of great assistance to a physician in explaining his decision to protesting parents. But there is another point in favor of a mandatory law. Whether cases of suspected abuse should be brought to the attention of the authorities responsible for child protection is not a medical question, but a question of social policy, properly answered by a legislature.

All 47 reporting statutes designate physicians of all kinds, and most of them also designate hospitals, as reporting agents. Some statutes and the American Medical Association's proposal reflect a judgment that the laws should also encourage reporting of suspected child abuse by members of other professions who see children regularly, such as nurses, dentists, teachers, and social workers. A few States provide that everyone who suspects a case of child abuse is covered by the statute.

The argument for focusing on reporting by physicians is very strong. Doctors face special confidentiality problems arising from the physician-patient relationship and are concerned about the threat of legal action. Actually, the chief aim of the legislation is to uncover cases which only medical skill can detect in the course of a medical examination and a review of the medical history. The obvious cases of maltreatment are likely to be identified by persons in the community who, at least in cases of serious injuries, bring them to the attention of some authority or agency which can take action. If the statute's reporting group is large, the impact of the reporting requirements may be diffused. Everybody's duty easily becomes nobody's duty.

Recipients of reports

The Children's Bureau proposal of 1963 recommended that reports of suspected child abuse be made "to an appropriate police authority." The police authority was designated originally because it "constitutes the only chain of services which is sure to exist in every community." [7] Moreover, police are available 24 hours a day.[7]

On the other hand, The American Humane Association has recommended that suspected cases be reported to the public or voluntary child welfare service which carries the child protective function in the community.[8]

Because, since 1963, public child protective services are becoming more widely available as part of comprehensive child welfare programs in the States, the Children's Bureau now recommends that in communities where a public welfare agency offers child protective service it be the agency designated to receive reports.

The 47 State statutes vary greatly with regard to the agency designated to receive reports. Some designate the police, another law enforcement agency, or the juvenile court. Some designate public or voluntary child welfare agencies, or both. In many States, more than one type of agency is designated.

The designation of the police or other law enforcement authority as the recipient of reports creates all sorts of problems. The investigative skills of the police, the sheriff, or the prosecutor are useful in answering the question, "Who did it?", but they are not likely to be of much use in answering: "Why was it done?", "What can be done to preserve the family?", or "How can this child be protected?" Law enforcement officers habitually look for a basis for prosecution, but are often blind to danger signs present in a home situation which would be apparent to a properly trained social worker. Investigation by a law enforcement agency is likely to engender defensive hostility in the parents and make successful intervention by a child welfare worker impossible. The child protective service of a child welfare agency possesses the greatest fund of desirable resources to focus on what happens to the children involved.

There is a growing trend, as evidenced by the statutes adopted or revised in 1965, toward the designation of the public welfare department either as one of the agencies to receive reports or as the agency to carry the chief responsibility for making the initial investigation following a report.

If reports are to be made exclusively to public welfare departments, however, some provision should be made to provide for round-the-clock emergency service. Illinois has initiated a unique system of statewide emergency service which can be reached by calling a well-publicized telephone number.

Statutes which provide a choice of agencies to receive reports in the same community bring uncertainty to administration and confusion to those who are obligated to report. Worst of all, none of the designated agencies may have a clear responsibility for action. Of course, a State may find it necessary

to designate different agencies as exclusive recipients of reports for different parts of the State. Resources available in one community may be absent in another.

In two States, California and Illinois, under the provisions of State law, and in a few cities, for example, New York, under local administrative regulations, reports of instances of suspected child abuse are recorded in a central registry. Parents who abuse their children sometimes go from doctor to doctor and hospital to hospital in an attempt to escape attention. A central registry helps to identify these "repeater" cases, and can help determine the significance of the present injury. Knowledge of a previous report of suspected abuse can help confirm suspicions that an injury is the product of abuse.

A central registry also serves an important statistical function, which can lay the basis for learning more about the nature and causes of child abuse. Some State and local welfare departments collect information for statistical and research purposes only, without making specific case information available to physicians and social workers.

Some questions about the effectiveness of reporting statutes probably never can be answered. For example, we cannot prove that reporting laws actually cause more cases to be identified than before. Records of casefinding were not previously kept. And, we do not know how many abused children, if any, are deprived of medical attention because their caretakers are afraid of being reported. Such cases are not recorded.

Nonetheless, the facts at hand provide a compelling argument that reporting laws are having an important impact. First, reports *are* being made under the statutes and in increasing numbers. Dr. David G. Gil of Brandeis University, director of a nationwide epidemiologic study of child abuse,[11] estimates that approximately 5,000 cases will be reported under these statutes alone in 1966. In the first year under the New York State reporting statute, reports involving 424 children were received. In the second half of the year, the rate of reporting increased.[12]

The reporting legislation has spurred the establishment of new public services aimed at child protection. In some States new legislation has been passed requiring or authorizing child protective services, and in others additional services have been provided under existing laws. In some States, after a reporting statute has been passed, legislators have made additional money available for child protective services.

Legislation alone does not bring reporting. In some places where the child abuse reporting laws have been most successful a burst of cooperative activity has taken place. Newspapers, medical societies, and welfare departments have alerted the citizenry and the medical professions about the reporting statute. Hospitals have established regular channels for reporting cases, and communities have created the machinery to help physicians comply with the law.

Reporting is, of course, not enough. After a report is made, something has to happen. A multidisciplinary network of protection needs to be developed in each community to implement the good intentions of the law. If child protective services are not available, reporters will no longer report. The promise of casefinding legislation, such as reporting laws, is that when a case is found, something is done about it. The legislatures which require reporting but do not provide the means for further protective action delude themselves and neglect children.

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[1] *In the Matter of* S. 259 N.Y.S. 2d 164 (Fam. Ct. 1965).

[2] National Probation and Parole Association (now National Council on Crime and Delinquency): Standard juvenile court act, sec 8, 2(B). New York. 1959.

[3] Paulsen, Monrad: The delinquency, neglect, and dependency jurisdiction of the juvenile court. *In* Justice for the child. (M. K. Rosenheim, ed.) The Free Press of Glencoe, New York. 1962.

[4] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Standards for specialized courts dealing with children. CB Publication No. 346. 1954.

[5] New York Family Court Act, sec. 354.

[6] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Proposals for drafting principles and suggested language for legislation on public child welfare and youth services. 1957. (Multilithed.)

[7] U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: The abused child—principles and suggested language for legislation on reporting of the physically abused child. 1963.

[8] The American Humane Association, Children's Division: Guidelines for legislation to protect the battered child. Denver, Colo. 1963.

[9] Council of State Governments: Program of suggested State legislation. Chicago, Ill. 1965.

[10] American Medical Association: Physical abuse of children—suggested legislation. Chicago, Ill. 1965. (Mimeographed.)

[11] Gil, David G.: Epidemiologic study of child abuse—research in progress. Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University. 1965.

[12] Report of the New York State Department of Welfare, Albany. Nov. 30, 1965.

The variety of approaches that can be taken toward improvement of services for the retarded are suggested by the following two articles which describe, from different perspectives, some of the many innovations that have been taking place within one State.

OWEN E. FRANKLIN

DONALD J. BAKER

improving an institution's services for the retarded

Public institutions for the mentally retarded have long been handicapped by shortages of professional workers, limited funds, overcrowding, long waiting lists, and isolation from the mainstream of society. Paradoxically, they have been constantly pressed to admit more patients and at the same time to improve their services. Confronted with these problems and with the growing public interest in the quality of programs for the mentally retarded, many such institutions have been searching for solutions which would help them not only to improve their intramural services, but also to integrate them with an overall community program for the retarded. Woodward State Hospital-School at Woodward, Iowa, is among them.

Woodward is one of Iowa's two State institutions for the mentally retarded. Five years ago, the institution was so overcrowded that in some of the wards beds were lined along the wall flush with each other with no space between. A long waiting list was growing steadily as individuals and communities vied for priority for their candidates. Numerous, often conflicting, calls about particular children awaiting admission created confusion in admission practices. Community-based services for the mentally retarded were sparse and uncoordinated.

Sadly lacking in the institutional program were: (1) sufficient attention to differential planning and programing for the patients on the basis of individual diagnoses; (2) clear admission and release policies; (3) planned preadmission and aftercare services; (4) strong ties with the outside community; (5) sufficient professional personnel of all types. For example, the institution's seven-member social service department included only two persons with master's degrees in social work—the director and the social service supervisor.

In 1961, the institution began a unified effort to improve the quality of its services, reduce both the patient load and the waiting list, and become an integral part of a many faceted State and community program for the retarded. In this effort, it had the backing of the Iowa State Board of Control of State Institutions which had recommended that the institutions for the mentally retarded adopt a 4-point program to (1) transform the two institutions to specialized treatment, training, and care centers; (2) cooperate in the development of adequate extramural services; (3) develop inservice training for all types of staff; and (4) encourage research into clinical and administrative practices.

Involving the entire staff, the institution's effort to revitalize its program proceeded through two main lines of attack: (1) devising methods for the more effective use of professional and auxiliary staffs; and (2) keeping the staff, and hence the institution and its patients, in closer touch with the outside community. Today, the institution has about

A multidisciplinary team at Iowa's Woodward State Hospital-School discusses a plan for a patient's treatment and care.

1,000 resident patients as compared with nearly 1,700 5 years ago, and its waiting list has been abolished. What is more important, its patients, both inside and outside the institution, are receiving more of the kind of attention they need to help them function at their best.

This article will focus on the role of the social service department in these developments. However, since this role was closely integrated with the entire revitalization program, a brief description of the framework in which it has been carried out is pertinent.

At the beginning, the administration decided that the institution, which consisted of 37 buildings, including 13 residences for patients, would be divided into 4 administrative areas and that an interdisciplinary team would be set up to serve the residents in each area. Each team would consist of a physician, a psychologist, a social worker, an educator (academic or vocational, depending upon the ages and needs of the residents in the area), a chaplain, a recreation worker, a ward attendant, and a representative from Nursing Attendant Service. Previously, the professional members of the staff had their offices in a central administration building, far removed from the residential buildings. Now each team office would be located within the area of the institution for which the team was responsible, thus putting the clinical staff in regular touch with the residents and so providing more opportunities for interaction between them.

The plan was for the teams to begin to work immediately on a "crash" program of evaluating the functioning level and potential of each resident and to follow each evaluation with habilitation services according to individual needs. One of the purposes was to determine which residents had needs that could best be met in their home communities and which needed further training or care within the institution.

While this program got under way, the new administration assigned staff members to a preadmission evaluation clinic and named the director of the hospital's social service department as chairman. Other staff members of the clinic included a physician, a psychologist, a director of nursing, the director of the institution's education and training department, the registrar, the chaplain, and the social service supervisor. The purpose of this clinic, which replaced the institution's previous diagnostic clinic, was to provide the kind of selective admission process which would enable the institution to furnish a specialized program of training and education to its residents.

In order to carry out this overall plan, the administration set up a clear-cut salary budget for each department designed to attract more professional workers to the institution and to reduce staff turnover.

Social service priorities

At the time of this reorganization, the administration delegated to the social service department several specific responsibilities: major responsibility for determining who is admitted; strengthening ties with communities; arranging for the return of patients to their own communities on the basis of a decision by the area team; and participating in the intramural team staffing arrangement. This meant new and greatly increased responsibilities for a department which had heretofore largely confined its efforts to interviewing parents of the patients, writing case histories, corresponding with relatives, and finding jobs in the community for some of the higher functioning residents. The department would now have to address itself to two broad objectives:

1. Offering individual services to deal with the social, emotional, and environmental problems of patients and their families, before, during, and

after the patient has been placed within the institution.

2. Fostering and maintaining a constructive relationship between the institution and the community to help the community bring about more nearly adequate social services for the retarded.

Obviously, making the best use of all available staff members would be the key to the department's effectiveness, and in this effort the clear-cut salary budget would be a great help.

As a basis for a logical consideration of its personnel needs and uses, the department established the following specific goals, in order of priority:

1. Participate in the evaluation of all the residents.
2. Contribute to strengthening the preadmission evaluation process.
3. Recruit additional persons for the staff.
4. Initiate a series of meetings with the county board of supervisors in each county served by the institution, as the Code of Iowa places administrative and financial responsibilities on this body for the care of the mentally retarded at the county level.
5. Promote an organized release and aftercare program.
6. Improve social services within the institution.
7. Provide inservice training and other means of development for the department's staff.
8. Conduct service-related research.

The department then initiated an intensive recruitment program to secure the type of manpower commensurate with these goals—social service representatives to work full time outside the institution as community consultants and social service representatives to work in the institution on the professional teams. Simultaneously, the department initiated communication with the county boards of supervisors to pave the way for future meetings between representatives of the institution and the boards to discuss ways in which the institution and the county boards could work together in the interests of the mentally retarded. At these meetings, the institution offered its consultation service to the counties.

The needs of patients, the institution's budgetary limitations, and the shortage of graduate social workers, considered together, resulted in a plan to have two levels of social service staff—persons with graduate degrees in social service and persons with bachelor's degrees only. This plan emphasized the importance of having a good and continuous staff development program.

Research activities, it was decided, would have to be developed later and directed primarily toward the study of factors bearing upon the development of the community services program.

Assessment of client needs

The next step was to determine the deployment of the department's staff to provide the best social service coverage possible within its means. This meant defining the tasks involved and determining which required the skills of a graduate social worker and which could be performed under professional supervision by a person without formal social work education. To do this, it was essential to determine the needs of the department's many types of clients. These included (1) the communities of 48 counties; (2) the retarded people in their populations; (3) the various agencies which could serve the retarded; (4) the institution's residents and their families; and (5) the professional teams.

In the communities, local agencies, such as the county welfare department, the public health nursing service, the schools, the courts, and the associations of parents of retarded children, needed a helpful relationship with someone who had knowledge of mental retardation, the State and national resources for dealing with the problem, and the roles of the family, the institution, and the community in meeting the needs of the mentally retarded. They needed to know that the institution's policies in relation to their county would be based on an individual assessment of the county's resources. They needed an opportunity to express freely their attitudes toward the institution, its program, and its policies. And they needed someone to help stimulate more effective cooperation among social, educational, medical, and

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Both Owen E. Franklin, left, and Donald J. Baker write of Iowa's Woodward State Hospital-School out of experience in its social service department. Mr. Franklin was director of the department before coming to the Children's Bureau in 1964 as specialist on social services to mentally retarded children. Mr. Baker, presently assistant director of the department, joined its staff in 1961 as social service supervisor.

citizen groups and the agencies in the locality.

The patient, on his admission, needed at least someone to help acclimate him to a strange, large, relatively impersonal institution—someone to tell him about what might happen to him, help prepare him for its programs and services, and help him feel accepted. Above all, he needed emotional support and assurance that his family or someone still cared for him and about what happened to him. Later, if he were to leave the institution for home, temporarily or permanently, or to be placed in another community facility, he would need preparation for the change.

The parents of the patient needed someone to help them deal with the many problems they would face during the admission process and to keep them informed of their child's progress in the institution. They needed assurance that the institution was interested in the family and was willing to help them maintain contact with their child, and they needed to be drawn into the planning for the aftercare of their child.

The professional teams, with responsibility for the specialized treatment, training, and care of the residents in their respective areas of the institution, needed to be kept aware of developments within each patient's family and the resources available to him in the community. They needed to know the kind of family conditions or substitute care to which the patient would go, if recommended for release.

After thus analyzing the needs of its clients, the department assigned the community work to its staff members with graduate social work degrees, because functioning effectively as a community consultant implies a high degree of autonomy and requires a variety of social work skills. Staff members with bachelor's degrees only were assigned as social workers on the institution's area teams to work under the close supervision of the social service supervisor and were provided with a continuing program of inservice training.

The community worker

The three community consultants each spent about 3 months in the institution to become oriented to its programs and objectives. They attended the area team meetings and participated in regular discussions with the administrative staff about their community responsibilities.

The social service director then arranged with the county boards of supervisors for an introductory visit from the consultants to be assigned to their counties. At the conclusion of each of these initial meetings, the county board was requested to designate a county employee to provide liaison with the institutional community consultant in planning for the mentally retarded. This they did, and the person so designated, usually the director of the county welfare department, came to be known as the "county designate" and became the focal point for merging community and institutional interests in the mentally retarded. From then on, the community consultants worked through the county designate's office to involve the health, education, and social agencies of the community in individual case planning and in community program development. The community consultant offered help in case planning whether or not institutionalization was being considered.

Each community consultant lives within the group of counties he serves. His office is his home.

Among the consultant's specific activities are:

- Establishing a working relationship with the county boards of supervisors and their designates, and with other community leaders as necessary, to coordinate case-by-case planning for the mentally retarded both in and out of the institution.
- Helping county designates understand the needs of retarded people and the implications of specific methods for meeting them.
- Helping the county designates and other interested persons understand the emotional factors associated with mental retardation.
- Demonstrating methods of dealing with such emotional factors in specific cases.
- Studying local communities to find resources for the mentally retarded; suggesting ways of using them more effectively; and stimulating the development of new programs.
- Stimulating a cooperative approach to problems at the community level.

From the beginning, the department recognized that the community consultant might be exposed to resistance, misunderstanding, and outright antagonism. Some of these negative reactions would be based on actual past experiences with the institution; some, on a preference for local, as opposed to State, programing; some others, on resistance to the new preadmission and release policies; and still others, on a reluctance to develop new services at a time of high costs. Hence, an opportunity was provided for staff members, "on the firing line" in communities, to spend at least 2 days a month within the institution to consult with the administrative staff and team

members individually and in meetings. They were also brought into the institution at intervals to substitute for the social service supervisor or the director of social service in order to help them maintain their identity with the institution and to develop professional versatility. While working in their communities, the consultants were encouraged to telephone the social service department whenever they felt the need. They sent in regular narrative reports of their activities, findings, and impressions. Further, they were encouraged to attend various professional meetings in the State, and each year one consultant was selected to attend an out-of-State meeting on a topic related to the institution's work.

Area team social workers

As vacancies occurred rather quickly among the nongraduate social workers who were already on the staff, their positions were filled by recent college graduates interested in careers in social work. These recruits were selected for their apparent warmth and concern for people, their interest in mental retardation, and their flexibility.

The new team social workers spent the first months or so in an orientation program in the administration building, which included instruction and job assignments under the close supervision of the social service department. During this on-the-job training, they attended meetings with the teams to which they were to be assigned as well as with other teams. Thus, theory was immediately combined with practice.

After their assignment to their area teams, they remained under the supervision of the social service supervisor and continued to attend staff meetings with the social service staff, the community consultants, and the administrative staff. They had ready access to the social service supervisor or the director for assistance in handling their work assignments.

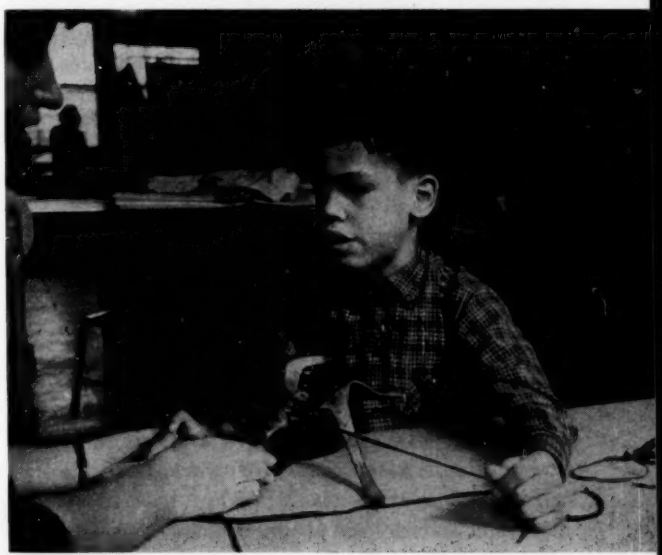
As a member of the professional team, the team social worker contributes information about the resident, his family, and the community to the other team members. In addition, he carries out the team's recommendations related to the social service department's responsibilities. Some examples of other tasks performed by team social workers are:

- Interviewing parents, other relatives, and guardians in regard to the resident's progress, referral to other agencies, and tangible needs such as money and clothing.
- Serving as liaison regarding specific patients between the team and local agencies, parents, and other interested persons.
- Serving as liaison between the team and the social service department.
- Conducting individual tours of the institution for parents of prospective patients.
- Helping prepare new residents for their stay at the institution, providing them with a supportive relationship while they are there, or preparing them for release to their own homes or to community facilities.

These tasks were assigned to college graduates without social work training. The contacts with patients and families they involved were brief and concerned only with tangible needs. The department realized that many patients and their families needed intensive social casework of a kind the team workers were not able to supply. However, the tangible services of the team social workers were important to both residents and their families. The addition of more intensive service remains a goal for the future for the institution.

In addition to having an "open door" policy for the team social worker, the social service supervisor scheduled weekly conferences with each one. After the new program got well under way, the department initiated a series of bimonthly seminars to introduce

A retarded boy, with adult guidance and understanding, learns the simple but useful skill of lacing a shoe.



social work knowledge, attitudes, and skills. Subjects discussed in the seminars included principles of interviewing, recording, social work methods, human growth and development, professional development, and public welfare. Lectures on mental retardation by staff members of other departments were also included in the seminars. The team social workers were encouraged to use the new professional library being developed within the institution and to attend social welfare meetings held by various organizations within the State.

Some results

In the 5 years since the inauguration of Woodward's unified effort to improve its services, and the resultant expansion and reorganization of its social service department, the institution has experienced a noticeable acceleration of turnover in its residential population—an important indication that it has been accomplishing at least some of its objectives. For example, only 34 patients had been admitted in 1960, because space was not available for more. In 1964, the number of admissions had quadrupled to 136. Yet, in spite of a steady increase in admissions, the number of residents was reduced to 1,010 by July 1, 1965, as compared with 1, 648 on July 1, 1961. Full discharges increased from 153 for 1960 to 204 for 1964. The residents on leave within various community facilities—own homes, foster homes, group custodial homes, and nursing homes—increased from 192 in 1960 to 596 by July 1, 1965. And, as already mentioned, the waiting list for admission has been eliminated. Nevertheless, all plans for admission or release have been worked out on an individualized basis involving parents and community agencies.

Behind these developments lay hour upon hour of ponderous effort by the institutional staff in working, case by case, with local agencies (which were sometimes suspicious of the institution because of past experiences) and with parents who often viewed their child's institutionalization as the "end of the line."

Undoubtedly, one of the most important results of this effort is the partnership formed between the institution and community agencies for developing local services for the mentally retarded and their families. Because the original three community consultants are still on the staff, the relationships between institution and the outside world have retained continuity—relationships which are born of mutual involvement with local people in connection with real cases and with the needs of the community.

The social service staff development and supervisory arrangements have not only helped hold staff members with graduate degrees in social work but have also helped enlist recent college graduates into social work. There has, however, been a complete turnover of staff members with bachelor's degrees only, although all who have left have expressed satisfaction with their experience in the institution. Of the first five who left permanently, three went on to graduate training in social work; one took other employment in a hospital social service department in her home town; another left to get a master's degree in a related field, special education. Another worker left to attend a school of social work on a stipend provided by the institution and since graduating has returned to the institution to work.

Reduction of the institution's population was as important as increase in staff in improving professional services, for this reduction also brought about a better staff-resident ratio. Residents are now evaluated thoroughly twice each year for the adequacy of their programs or needed change. The fluidity of movement of patients to and from the institution makes it possible for the institution to provide its patients with a truly dynamic program of training, treatment, and habilitation.

These efforts to improve Iowa's services for the mentally retarded may have much broader significance than the accomplishments in the program for which they were devised. They were a conscious attempt to try out ideas which have been discussed widely in recent years among persons concerned with services to the retarded, for example: to use two educational levels of social service staff in different ways; the deliberate plan for making the institution a part of a continuum of resources for comprehensive care, through the provision of the community consultants; the use of the mental retardation specialist to help the generalist—and again through the community consultants working with the employees of local health, education, and welfare agencies; and the establishment of a referral point in each locality for problems concerning mental retardation—the county designate backed up with consultation and service from the community consultant.

Above all, the institution's experience demonstrates the effectiveness of a give-and-take attitude on the part of all concerned in bringing about greater coordination and development, both in quantity and quality, of services for the mentally retarded and their families.

opportunities to serve the retarded prompt a State crippled children's agency to develop its . . .

SERVICES FOR CHILDREN WITH MULTIPLE HANDICAPS

JOHN C. MacQUEEN, M.D.

The 1963 Federal legislation providing Federal financial support for services to the mentally retarded [1] offered a new opportunity and a new obligation to State crippled children's agencies. Accordingly, the Iowa State Services for Crippled Children has made changes in its existing programs and established new ones to provide better care for mentally retarded children, especially those with multiple handicaps. In describing these changes briefly in the following article, I have no intention of implying that Iowa's programs should be adopted by other crippled children's agencies, or that they are the best that can be designed. My purpose is to stimulate the interest of other crippled children's agencies to increase and improve their programs for multiply handicapped children in keeping with the needs of their State.

I am, of course, aware that the legal definition of the responsibilities of a crippled children's service varies from State to State. In some States the programs provide services only for children who have a few specific diagnoses; in other States, they provide services for children with almost any kind of handicapping condition. While State crippled children's programs rarely provide complete services for retarded children who have no physical handicaps, few State programs exclude the retarded child if he has a physical handicap. Therefore, most State crippled children's agencies have a basis for increasing their services for the retarded and the multiple handicapped child by using the Federal funds earmarked for the mentally retarded.

When we began to consider how we could do this in Iowa, we reviewed the needs of children in our State who are both physically and mentally handicapped. In doing so, it became apparent to us that the responsibility for meeting many of the needs of these children should remain with the local welfare, health, and school facilities—for example, the provision of such everyday necessities as educational experiences, training for self-care, and the development of vocational skills. These services can appropri-

ately be provided through such facilities as local preschool day-care units, special education classes for the multiply handicapped in school systems, and sheltered workshops for handicapped adolescents.

Our review indicated that communities in Iowa were slowly accepting their responsibility to provide such services. The direct provision of these services by the State crippled children's agency seemed neither appropriate nor feasible. What the communities needed was consultation and encouragement from specially trained persons who could help them develop programs that would provide high-quality care to each child. Most communities have neither the resources to hire persons highly skilled in diagnosis or in supervising high-quality programs for the care of the multiply handicapped retarded person nor a caseload sufficiently varied to attract them. Our crippled children's agency, like other crippled children's agencies, includes on its staff persons with these special skills who could appropriately serve the communities as consultants.

Therefore, we decided to expand the State crippled children's program to provide the needed consultative services and thus interlock the agency's efforts with community programs for multiply handicapped retarded children.

In further reviewing the State program for handicapped children, we found that some of the services for the multiply handicapped offered by the crippled children's agency could be immediately expanded; some new services could be easily activated; and some new services, broad in scope, would require long-term planning and development. Most of the expanded services could be carried out by the agency's staff. The new services would require recruiting of new or additional staff. The activities and services requiring long-range planning would, for the greater part, involve complicated cooperative effort with other State agencies.

Mobile clinics

Our mobile field clinic was one service we could immediately expand. This diagnostic field clinic, which conducts 45 to 50 clinics a year throughout the State, has a long history of providing a high-quality, multiple-disciplinary clinical service. Before additional Federal funds became available, it was not possible to provide as many services as we wished for the retarded, physically handicapped child. With the additional funds, it became possible to enlarge our staff, particularly our staff of clinical psychologists and speech and hearing specialists, and to provide the needed diagnostic services for the retarded, physically handicapped child.

For several years, we had been trying different methods in the clinic of serving children having emotional problems or problems related to retardation. We came to believe that such children would profit by a special sequence of examinations. Therefore, we instituted and continue to use the following procedure.

After the child's parents are interviewed by a social worker for the purpose of taking the child's history and identifying the problem, the child is examined by a pediatrician, a clinical psychologist, and other specialists as needed. At the conclusion of this sequence of examinations, the child and his parents return to the social worker for the discharge interview. The results of the examinations are available to the social worker, who may counsel the parents and, in particular, assist in designing a program of followup care.

Recently, we conducted a followup study of the children handled in this fashion during the field clinic examinations. We found that, on the whole, the parents responded positively to the experience and had, in a high proportion of instances, followed through with the suggested program of care. This confirmed our confidence in this examination procedure. Therefore, we have adapted it for use with the multiply handicapped retarded child, and believe it to be extremely effective.

After each field clinic, the regular clinic staff—a pediatrician, a social worker, a public health nurse, a clinical psychologist, a speech and hearing consultant, a physical therapist—holds a community planning conference with representatives of the local school system, the welfare department, and the department of health. The staff reviews the records of selected patients examined in the clinic, discusses the clinic findings and recommendations, and helps the local people to plan an appropriate followup program.

Experience has proved these conferences to be extremely important. We are convinced that the recommendations must be carried out by local people and must be in keeping with available facilities. To

suggest that a child attend a special day school if such a school does not exist in the community is not only unrealistic but can disrupt other aspects of his program. A more realistic recommendation for him might be to enroll him in a twice-a-week physical therapy program that is available.

Iowa is largely a rural State. One of the major difficulties in achieving good followup care for crippled children is in making arrangements to provide the specific educational and treatment programs needed by the multiply handicapped child. We have found that it is more difficult to organize community services to provide for the complex needs of the multiply handicapped child than for almost any other type of patient in our program.

In an attempt to further services for this type of patient, the crippled children's agency and the State Department of Public Instruction have created a joint position of consultant for the multiply handicapped. With training in special education, psychology, and physical therapy, this consultant helps communities make arrangements to provide the appropriate programs for specific handicapped children, especially children with particularly difficult problems who live in communities where health and educational services are limited. In thus demonstrating what can be done with appropriate effort for a multiply handicapped child, the consultant encourages the community to more nearly meet its needs. Our experience has indicated that in most communities there are people who will go to great lengths to make necessary arrangements to carry out appropriately designed programs for a handicapped child if they are informed about his needs. When the people of a community begin to see the advantages of specialized education and therapy programs, they begin to demand that the necessary specialists be employed to provide them.

Work with institutions

As the State agency for the care of crippled children, we have also considered the needs of the retarded children who reside in the State's two hospital-schools for the retarded. [See page 49.]

To find out whether we could be of assistance, we visited one of these institutions. We realized that we could provide only token assistance in alleviating the problems which the institutions face. In our discussion with the institution's administrative staff, it was agreed that the crippled children's agency could help in two ways:

Efforts are being made in many places to bring better services to multiply handicapped children, such as this one.

1. By organizing a consultant team from our staff to include a pediatric neurologist, a pediatric orthopedist, and a speech and hearing examiner to go to the State hospital-school at regular intervals to review selected patients.

This consultative service, which is now getting under way, is expected not only to help the individual patients involved but also to provide valuable training experience for the agency's staff and the institution's staff.

2. By conducting a study of the indications for orthopedic surgical procedures for patients with severe skeletal-muscular problems.

This study is being carried out through the joint efforts of the staff of the crippled children's agency and of the State institution. A service-research activity, it has as its first purpose to evaluate the efficacy of surgical procedures in altering the kind of care a retarded patient with severe orthopedic handicaps must have, rather than to rehabilitate individual patients. A program designed to treat surgically all the patients in the hospital for all possible orthopedic needs would be beyond the professional and financial

resources of the State crippled children's agency.

Under the study, the institution's patients are classified according to their functional disability and degree of retardation. Cases are matched, and alternate cases have surgical procedures performed by the orthopedic consultant. We hope that 5 years hence we will as a result have much better information than we have had about the indications for orthopedic surgery in retarded children who have severe physical disability.

Other programs

Various members of the staff of the Iowa State Services for Crippled Children have designed and instituted new programs to increase the agency's services for the mentally retarded.

For example, one of our consulting pediatricians, who has a special interest in the newborn, in cooperation with a consulting obstetrician of the University of Iowa Hospital, has established a program to consider the problems of high-risk mothers and infants. In this program, mothers and infants with obstetrical and neonatal problems known to be related to physical handicapping and mental retardation are selected for study. Their problems are carefully documented in the medical center and a program of followup care, involving the staff nurses of the crippled children's agency, is maintained. Special clinics are conducted in various parts of the State for continued evaluation of these infants.

This study program illustrates an important change in our approach to medical care for infants. Before it was begun, we would have waited for the child to be referred to our service by his local physician when, and if, a handicap was noted. The results of the study may well have important implications for the design of future programs of care for high-risk infants and mothers.

Another of our pediatric consultants established a program, in cooperation with the mental retardation diagnostic clinic supported by the Division of Maternal and Child Health of the Iowa State Department of Health, to provide services for children with phenylketonuria. This program includes case-finding, studies of the families of children known to have phenylketonuria, the provision of hospital care, the purchase of the essential dietary supplement, and the provision of followup home care. The program is demonstrating the advantages of providing carefully supervised care for children with this condition and of having a special clinic where the children can be evaluated and the parents can come to discuss their problems with professional persons and with other parents of children with phenylketonuria.

The director of our speech and hearing division, who is particularly informed about the development of speech in mentally retarded children, has designed a program to evaluate the effectiveness of speech therapy provided for retarded children in special education classrooms. This program combines a special service function with a clinical research activity. Supported by a special grant from the Federal Children's Bureau, it is part of a training program for professional persons in the field of speech and audiology who are or will be working with mentally retarded children.

Long-range planning

When we considered what the crippled children's agency might do for the multiply handicapped, we recognized that our achievements would be limited if we concerned ourselves only with services that we could provide by unilateral activity. Programs are needed in our State that require long-range interagency planning. For example, the number and quality of preschool day-care facilities for mutiply handicapped children leave much to be desired. Such facilities as we do have are for the most part poorly financed, inadequately staffed, have little medical supervision, and rarely provide the kind of comprehensive training needed by multiply handicapped children. A major problem is that no section of society or government has been clearly assigned the responsibility for the creation, support, and profes-

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sional supervision of facilities of this type.

There are a few facilities within the State that provide services and care for the multiply handicapped school-age child. These are most commonly a part of an enlightened school system.

Several years ago it became accepted practice in Iowa for moderately handicapped children to be retained in their homes and community rather than in a State residential school. Because many of these children are now adolescents, we are now confronted with the inadequacy of our community services for the multiply handicapped adolescent. The moderately handicapped adolescent has usually completed any special education program the community offers. He has no place to go. He cannot happily remain inactive in his home. He needs sheltered workshops and related facilities, but these are lacking in most communities.

In our State, those of us who have been planning services for the retarded have been impressed with the possibilities of rural counties combining their efforts to provide special services and facilities for disadvantaged persons. Specifically, we are proposing that regional units be created to serve a 6-to-8-county area with a population of approximately 150,000 people. Each regional unit would offer, among other services, special services for multiply handicapped children and adults, including day-care facilities, rehabilitation services, and sheltered workshops.

These combined county units will no doubt take several years to develop. As they do develop, the growing activities of the State Services for Crippled Children will enhance their effectiveness. Specifically, we propose to provide a traveling diagnostic-consultative clinic for the multiply handicapped children in the units. We would be greatly concerned about the development of such units if a multiple-disciplinary consultative service were not responsible for the patient care.

As our agency became involved in long-range planning, we found that information about the prevalence and needs of multiply handicapped children in Iowa did not exist. Therefore, in conjunction with the Special Education Division of the Iowa State Department of Public Instruction, we carried out a case finding program in a six-county area, and followed this up with a series of special clinics for extensive examination of the children. Our experience in this project will be helpful in preparing specific recommendations concerning the development of regional units.

In addition to the pragmatic information we obtained about the incidence of specific handicapping conditions, we made two important findings about the needs of adolescents and young adults:

1. Many multiply handicapped adolescents, retarded and nonretarded, are living at home, without hope and without opportunities for education or vocational training. Some of these patients are not severely handicapped but simply have no place to go, no one to relate to, and so no purpose in their lives. Their parents, who were diligent and enthusiastic in seeking appropriate attention for them when they were small children, have gradually accepted defeat and no longer seek opportunities for them.

2. Some young adults have physical handicaps which could be alleviated by physical therapy or surgery. For example, a hemiparetic person could develop some vocational skills if he were to receive reconstructive surgery of the involved wrist and hand. In some instances, the indicated surgical procedures could not be carried out at an earlier time because the child was still growing. The patient became disinterested in followup examinations that were not helpful and failed to remain under medical surveillance.

Whence the support?

A reader may, understandably, ask: "Where are the funds to support such an expansion of services for multiply handicapped retarded children?" The answer is clear. Federal funds are available for State crippled children's services, especially for those services which expand or improve services for the retarded. In the past, the major factor limiting the expansion of services for multiply handicapped retarded children was the amount of money available. Today the major factor that will determine how far such services will be expanded is the degree of enthusiasm and the ingenuity of the staff of State crippled children's services.

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[1] Lesser, Arthur J.: Accent on prevention through improved service. *Children*, January–February 1964.

THE GENETIC BASIS OF SOME ABNORMALITIES IN CHILDREN

ELLEN S. KANG, M.D.

With increasing frequency, reports of biological research are appearing which indicate that abnormalities of chromosomes are the basis of many disorders and anomalies in children. The story behind this is a chronicle of ingenious application to human material of new techniques developed in the field of cytogenetics, which resulted in increasing demonstrations that abnormalities in numbers or structure of chromosomes are associated with some human diseases and anomalies.

Chromosomes are rod-like, darkly staining bodies in the nucleus of cells which are normally constant in number in each species and which contain the hereditary factors or genes. Before defining abnormality in numbers of chromosomes, it was necessary to establish the normal number of chromosomes in man. Tjio and Levan in 1956,[1] found that normal human somatic cells contain 46 instead of 48 chromosomes, as was previously thought to be the normal complement. This was quickly verified by others.

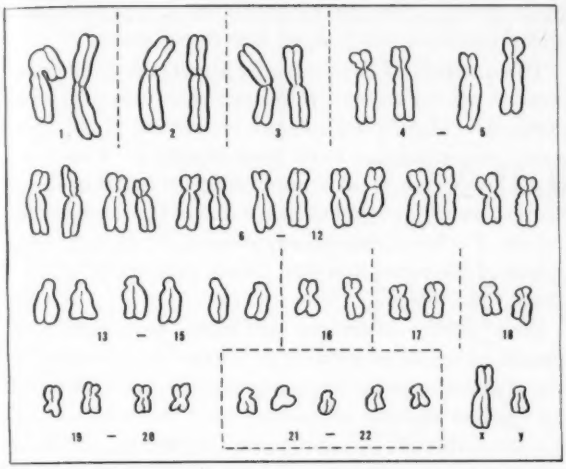
Differences in terminology and in systems of numbering chromosomes led to a conference of researchers held in Denver, Colo., in 1960, where a numbering system was agreed upon. This was based upon the arrangement of prepared, photographed, and enlarged pairs of chromosomes in decreasing size. Such a photographed arrangement of chromosomes is called a karyogram or karyotype. The chromosomes can be studied by characterizing the location of the centromere (a characteristic constriction in the chromosome), the overall length of the chromosomes, and the length of the arms on either side of the centromere. The ratio between the lengths of the two arms separated by the centromere is constant for any one chromosome pair.

It is possible with present technical means to detect abnormalities of numbers of chromosomes as well as some relatively massive structural abnormalities in individual chromosomes. The loss of nearly a half an arm from a small chromosome may be recognized, but a loss of a similar amount of genetic material from a larger chromosome may pass unnoticed. This amounts to a tremendous number of genes lost. The average chromosome is considered to have approximately 100,000 loci, the specific sites of gene location on a chromosome.

Normal cell division

In order to understand how abnormalities in the number of chromosomes might occur, it is well to recall the usual process of cell division. In simple cell division or mitosis, the distribution of chromosomes to daughter cells is precise with each cell receiving a full set of 46 chromosomes called a diploid set. Each chromosome doubles, completing the duplication from 46 to 92 chromosomes. The paired chromosomes separate and move to opposite daughter cells thus insuring the transfer of a full set of 46 chromosomes to each daughter cell.

In the development of the ovum and sperm, a reduction of the chromosome number of 46 by half to 23 chromosomes (known as a haploid) occurs in a process called meiosis. These haploids arise from specialized cells in the male and female organs. In meiosis two cell divisions are involved. In the first, the chromosomes group into 23 pairs before separating into two daughter cells in a process called disjunction. Each daughter cell has a haploid number of chromosomes—23. Before the second meiotic division, the chromosomes in these haploids duplicate so that there are 46 in each. Then another process of disjunction occurs, producing daughter cells with 23 chromosomes. Thus, one diploid precursor cell gives



The chromosome karyotype of a male afflicted with Mongolism. Note the extra chromosome between position 21 and 22, where there are normally only two chromosomes in each position. The X and Y chromosomes in the lower right corner are the sex chromosomes.

rise to four haploid products. From the mechanical point of view, the basic difference between meiosis and mitosis is that in meiosis two cell divisions occur with only one chromosomal duplication, while in mitosis each cell division is accompanied by chromosomal duplication.

The new individual human being begins as a diploid cell formed from two haploid cells, each donated by a parent. From this one cell the individual develops by repeated cell multiplications, the chromosomal complement of each cell remaining constant by the process of mitosis.

The wrong numbers

Failure of disjunction in meiosis can result in an abnormality in the total chromosome number. Lejeune et al in 1959,[2] made a historic report of the discovery of 47 instead of 46 chromosomes in patients with Mongolism. These patients were shown to have cells with an extra chromosome, or trisomy, at position 21. This extra chromosome was thought most likely to be contributed by the maternal ovum. This was suggested by the higher incidence of Mongolism found among children born of older mothers but no correlation was found between Mongolism and paternal age.

It is believed that a woman's sex cells are already present before her birth. The aging of these cells may result in damage predisposing to a failure of disjunction (nondisjunction). Both parents of Mongoloid children usually have a normal chromosomal complement in their somatic cells suggesting that the newly acquired extra chromosome occurred as a result of meiotic nondisjunction during gametogenesis, the development of the male and female sex cells.

Study of more cases of Mongolism resulted in reports of the presence of the normal complement of 46 chromosomes in somatic cells of some clinically typical cases.[3] However, the structure of these chromosomes was abnormal, with an extra chromosome in one group and a deficiency in another group. Such abnormalities are called translocations. The defect produces the same effect as an extra chromosome 21 and is inherited from carriers of translocations who are apparently normal, presumably because loss of chromosome material in them is relatively little.

Parents of children who are translocation cases are likely to be young. Clinical interest in finding carriers of translocation lies in the possibility of being precise in advising parents of a Mongoloid child of the risk for recurrence in subsequent pregnancies. There is suggestive evidence that mothers who are translocation carriers increase the risk of nondisjunction.

In Mongolism, nondisjunction may not be confined to the sex cell line. Several children have been found who have features of Mongolism and whose cells show several different karyotypes. This is called mosaicism and is thought to result from abnormal cell division during embryonic development.

Two other significant trisomic states have been reported—13–15 trisomy and 17–18 trisomy—in autosomes, the ordinary paired chromosomes as distinguished from sex chromosomes. In both these conditions, parents have apparently normal karyotypes. Both conditions cause early death. Single examples of several other autosomal trisomic conditions have been claimed. The most remarkable autosomal abnormality yet reported was a case with 69 chromosomes in a male with multiple congenital abnormalities.

The sex chromosomes

Investigation of cases of disturbed physical sex development has revealed many types of abnormality of the sex chromosomes. Chromosomal abnormality was originally suspected in such cases from examination of scrapings of the inside of the cheeks for the presence of a darkly staining intranuclear chromatin

body, normally found in females but not in males.

The normal male sex chromosomal pattern is XY and the normal female pattern XX. Abnormalities of the sex chromosomes have been demonstrated in four conditions: Klinefelter's syndrome, Turner's syndrome, the triplo-X female, and in some hermaphroditism and pseudohermaphroditism. Patients with Klinefelter's syndrome have a general male appearence with male external sex organs but are sterile, frequently mentally retarded, and have nuclear chromatin bodies characteristic of females. The sex chromosomal pattern of XXY is found in the majority of individuals with this syndrome.

Turner's syndrome usually occurs in persons who appear to be females but who are sterile, fail to show breast development, are retarded in growth, and have webbing of the neck. Most of them also have a congenital heart defect and are mentally retarded. In most cases, the sex-chromatin pattern is negative and the karyotype analysis reveals 45 chromosomes, only one sex chromosome being present. However, sex-chromatin positive cases of Turner's syndrome have been reported.

Several cases of females with an XXX pattern have been reported. Such women are usually fertile and their offspring normal.

Abnormalities of sex chromosomal patterns have also been found in a few patients with a confusion of sexual organs.

Chromosomal structure

The first clinical condition associated with a deletion of a portion of a chromosome was cat-cry syndrome (*cri du chat*) described by Lejeune.[4] This condition is characterized by a catlike cry and mental and physical retardation. It is associated with a deletion of the short-arm of chromosome number 5, and is definitely compatible with life. Heretofore, the deletion of a significant portion of an autosome, in contrast to such a deletion in a sex chromosome, was generally believed to be lethal. In one case of *cri du chat* reported by Lejeune, a phenotypically normal mother was found to have a balanced translocation between one of the 4–5 group of chromosomes and one of the 13–15 group. The carrier condition in a parent definitely increases the risk of future occurrence.

The question of chromosomal abnormality in spontaneous abortions and stillbirths has recently been pursued.[5] Highly significant incidences of chromosomal abnormalities have been reported. The relatively few types of such abnormalities noted in these studies are interpreted as being due to the more lethal nature of other chromosomal abnormalities, resulting in loss of the conceptus well before pregnancy is clinically established.

Well before technical advances permitted the identification of structural or numerical abnormalities of chromosomes, there was much evidence for the implication of these hereditary units in the causation of human disease and anomalies. Based on Mendel's investigations of inherited characteristics of peas, a system of genetic principles was developed which was extended by Garrod to disease in man,[6] thus laying the foundation for the study of heredity and inborn errors of metabolism.

Presumably, hereditary disorders of metabolism, such as phenylketonuria and galactosemia, involve a specific locus on a chromosome, or, more precisely, a molecular sequence on a locus and are not only undetectable by present-day cytologic techniques but may never be detectable by this approach. These disorders are better detected by biochemical techniques. Rapid advances in the recognition of these different types of expression of hereditary disorders have broadened the scope of genetics tremendously.

The basic value of the rapidly accumulated knowledge in cytogenetics rests in its immediate application in the practice of medicine, as in counseling parents on the etiology and irreversibility of the condition and the risk of recurrence in future pregnancies and possible rehabilitation of the patient.

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[1] Tjio, J. H.; Levan, A.: The chromosome number of man. *Hereditas*, 42: 1–2, 1956.

[3] Lejeune, J.; Gautier, M.; Turpin, R.: Les chromosomes somatique de neuf enfants mongolien. *Comptes Rendu Hebdomadaries des Séances de l'Academie Des Sciences, Paris, 248:* 1721–1722, Mar. 16, 1959.

[2] Polani, P. E.; Briggs, J. H.; Ford, C. E.; Clarke, C. M.; Berg, J. M.: A mongol girl with 46 chromosomes. *Lancet, 1:* 721–724, Apr. 2, 1960.

[4] Lejeune, J. et al.: Trois cas de délétion partielle du bras court d'un chromosome 5. *Comptes Rendu Hebdomadaries des Séances de l'Academie Des Sciences, Paris, 257:* 3098–3102, November 1963.

[5] Carr, D. H.: Chromosome studies in abortuses and stillborn infants. *Lancet,* 2: 603–606, Sept. 21, 1963.

[6] Garrod, A. E.: The Croonian lectures on inborn errors of metabolism. *Lancet,* 2: 1–7, July 4, 1908; 7379, July 11, 1908; 142–148, July 18, 1908; 214–220, July 25, 1908.

a school of social work takes the lead in . .

TRAINING NONPROFESSIONALS for A CHILD WELFARE SERVICE

LELA B. COSTIN

One of the most crucial problems in all the service fields today—including public child welfare—is the widening gap between available professional manpower and service needs. This has resulted in a growing realization that efforts to improve the quality of services cannot await the unforeseeable future when there will be enough professional social workers to fill all social work positions. The project to be reported here is one response to that realization. On the theory that schools of social work are in a favorable position to help agencies develop the potentials for useful service of "non-professionals" (persons without a graduate degree in social work), the Jane Addams Graduate School of Social Work, University of Illinois, in 1962 undertook a 3-year cooperative training program with 10 State public child welfare agencies. The project was focused on the agencies' responsibility for licensing family homes for child care.

The directors of the project reported here were Lela B. Costin and Jennette R. Gruener. Ellen Handler was research associate and Mildred S. Johnson, supervisor of training. The participating States were Illinois, Indiana, Iowa, Minnesota, Missouri, Nebraska, New York, Ohio, Pennsylvania, and Texas.

Financed in part with a Federal grant from the Children's Bureau, the project was based on two assumptions: (1) That an imperative first step in improving service today is a systematic analysis of the tasks in child welfare to determine those which the nonprofessional person can do effectively; and (2) that the licensing function can be used to raise the quality of care for large numbers of children. Since the plan and rationale of the study have been reported earlier,[1] this article will focus on the results.

The project had one central purpose: to demonstrate that the nonprofessional staff person can adequately perform the tasks involved in the licensing of family homes for the day care of children. Within this central purpose were six specific aims: (1) to identify the tasks in licensing family homes and the knowledge and skills needed to perform them; (2) to ascertain the relative importance of these tasks; (3) to develop a curriculum and set of teaching materials for a course to teach the licensing process; (4) to establish a level of competence against which a licensing worker's performance can be measured; (5) to demonstrate and evaluate three different ways of training nonprofessional persons for the licensing

tasks in order to identify some of the essential ingredients of an inservice training course for licensing workers; and (6) to determine, through evaluation of trainees' on-the-job performance, those tasks which the nonprofessional persons in the project performed successfully, those tasks which presented difficulty, and some factors in the difficulty.

Task analysis

A great deal of activity preceded the actual demonstrations. The first major step was *an analysis of the content of the licensing function.* The project staff and representatives of a public child welfare agency began by tentatively enumerating the tasks involved in licensing family homes. On the basis of this tentative analysis, areas of knowledge and specific skills that would be needed by the trainees were identified. The material developed provided the foundation for the draft of a teaching syllabus.

The next step was to spell out the tasks more clearly and to rate their importance according to the opinions of experienced social workers. Two panels of social workers were asked to indicate the relative importance of the tasks listed in fulfilling the agency responsibility for licensing family homes. Their responses were used in revising the syllabus, in constructing tests to measure a trainee's performance of the specific tasks, and in developing an overall standard for competence.

The first panel was composed of 92 social workers in 26 States having laws requiring the licensing of family homes and group facilities for the day care of children. All the panel members were designated by the supervisory staff of the licensing units in these States as staff members who could appropriately rate the importance of licensing tasks. The second panel was composed of 21 experts in 16 States, known to be especially interested, knowledgeable, or experienced in the licensing of family homes, who were engaged in work involving problems of licensing practice and the relationship of these problems to the use of scarce social work manpower. They included State child welfare administrators, staff development directors, day-care consultants, and State or regional supervisors of child welfare or licensing services.

The opinions of the two panels of social workers, in essential agreement, considerably extended the original analysis of the licensing function. Briefly, they said that the tasks which were most important in licensing family homes were those requiring skills in applying tangible standards to directly observable situations. They also agreed that the most important tasks were those which involved dealing with "primary" persons—applicants for a license, colleagues in the agency, or other persons who play a direct role in determining eligibility for a child-care license.

In contrast, tasks which received generally lower ratings were those requiring skills in applying more intangible standards, such as dealing with problems arising out of psychological situations. Other tasks rated as relatively low in importance were tasks involved in dealing with "secondary" persons—spouses and children of applicants, others in their household such as boarders and relatives, the applicants' references and friends, or the parents of children in family day care.

Further examination of the panels' opinions showed that the tasks with high ratings were most usually ones which would be carried out during the early steps in the licensing process—the application, the home study, or the formulation of a recommendation for issuance or nonissuance of a license. Those tasks which received low ratings were more often those which would be carried out while providing supervision-consultation to the licensee (a process in which the provision of consultation to the licensee is combined with the supervision of the home for its compliance with established standards), performing the community organization aspects of a licensing program, or offering service to the parents of children placed by their parents in family day-care homes without the intermediate service of a social agency—usually called "independent placements."

This difference between the nature of tasks receiving high and low ratings was consistent with a pattern of agency practice that the project staff had already observed. Tasks given high ratings of importance by the panels seemed to be those which are carried out most frequently, and which are most often included in a licensing program even when the agency cannot fully carry out its licensing responsibilities. The tasks receiving low ratings were those which are

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least often found in licensing programs, are not so well understood, and are most often dispensed with when pressures for other services are great and staff is in short supply.

For the purposes of the project, the tasks with the higher ratings were called the "central" tasks for meeting an agency's licensing responsibility on an acceptable though minimal basis. Tasks with lower ratings were called "peripheral" tasks for meeting the agency's minimal responsibility.

Other preliminary activities

The second major activity preceding the training demonstrations was the *preparation of a curriculum* [2] *and a set of teaching materials* [1] on which to base the instruction in the project. [See page 83.]

A third preliminary activity was the *establishment of a standard of competence* against which a trainee's performance on the job could be measured. This was done by considering the tasks essential in a licensing program—those which must be carried out if the public agency is to meet its responsibility, even minimally. The basic criterion identified by the project staff for determining a worker's level of competence was his performance in meeting the agency's minimal responsibility to the persons directly served by the licensing function and to the supporting public. As a result, a worker's previous training and experience were not considered criteria of competence. Instead, a judgment of competence was based directly on the minimal requirements of the task under consideration and the degree to which the worker's performance of the task met these requirements. Performance below that level was labeled as unsatisfactory, regardless of the worker's previous training or experience.

Responses of the panel of experts underwent a factor analysis to set the competence level on two of our evaluation measures: a supervisory rating scale for use by the agency supervisors and a record rating scale. Project staff consensus, with the experts' body of opinion as a guide, was used to set the competence level for tape recorded initial interviews, additional case record material, and results of a written test of a trainee's judgments of situations presented in case vignettes.

A fourth predemonstration activity was a *pilot training program* conducted by project staff on the school's premises for six trainees from the Illinois Department of Children and Family Services. The purpose of this early training program was to test the usefulness of cooperation between a school of social work and a State child welfare agency in training nonprofessional staff members and to test the feasibility of further investigation into the licensing function and ways of training nonprofessional persons for the tasks it requires.

The demonstrations

The project included three demonstrations, using different training procedures, involving a total of 41 licensing workers who had no professional social work education. Demonstration I included eight trainees from four States who took part in a training course conducted by the school of social work. Demonstration II involved two State welfare departments, each of which conducted an inservice training program for their own licensing employees, one for 10 trainees and one for 3 trainees. Demonstration III consisted of a course given by the school of social work for 16 child welfare supervisors from nine States, each of whom afterward trained one or more nonprofessional licensing worker. Altogether 20 workers were trained in Demonstration III.

The various groups of nonprofessional trainees were similar with respect to age, levels of education, social work experience, verbal reasoning ability (as measured by the Cooperative School and College Ability Test, Part I),[3] and attitudes toward family life (as measured by the Parental Attitude Research Instrument).[4, 5] We have no data to indicate whether these trainees were representative of the nonprofessional persons generally available to public welfare agencies. However, from our knowledge of the hiring procedures and recruiting methods used by the States which participated in the project, we assume that they were.

As an early assessment of the success of the training courses, we sought to answer the questions: "How much did the trainee learn from the course? Did he have significantly more knowledge of the content of the materials used when the course ended than when it began?"

An objective test was given to the trainees at the beginning and end of the formal training in each of the demonstrations. All but one had a higher score after completion of the course. The difference between the mean scores of the precourse and postcourse test was statistically significant for each group.

The various measures used for evaluation were aimed at the core of the investigation—determining the extent to which the nonprofessional trainee met at least minimum standards of competence in the per-

formance of the central and peripheral tasks in the licensing of family homes.

The employing agencies were clearly satisfied with the performance of the trainees during the 6-month period of work following training. Supervisors rated most of the trainees well above the level of competence which would meet minimum agency responsibility on all the tasks of licensing, both central and peripheral.

Growth of competence

Except for recording, the project's additional evaluative instruments similarly indicated that the trainees possessed at least minimum competence. They showed that most of the trainees could do most of the tasks involved in licensing family homes and especially those basic to the licensing process—receiving and handling applications, studying the home, and drawing together facts and opinions on which to base a judgment about whether or not to issue a license.

None of the trainees performed recording tasks at the level of competence set by the panel of experts as necessary to meet minimum agency responsibility, although the case records evaluated in the project had been accepted by the trainees' supervisors as satisfactory. The experts apparently set a theoretical standard for record writing different from the expectations in agency practice, thus illustrating a current confusion about the purpose and nature of social work recording. Other probable explanations for the trainees' failure to develop greater competency in this area are: (1) recording skills are difficult to acquire; (2) special attention was not given to recording either in the project's training sessions or in its consultation with the agencies about on-the-job training; (3) the traditional recording procedures of the agencies provided a sterile model for trainees.

About half the trainees apparently performed tasks successfully which in practice are not usually accorded a place of central importance in the licensing of family day-care homes and which are generally thought to be most difficult—aspects of community organization and the provision of supervision-consultation to the licensee.

An examination of the ways in which the trainees carried out community organization tasks showed that nonprofessional workers can be helped to develop a sense of community responsibility, to see the interrelationship of child welfare problems in general to their own day-by-day job, to furnish ideas to the agency, and to carry out community organization tasks effectively with the backing of their supervisors and administrators.

The community organization tasks carried out by trainees included:

- Interpretation of the licensing function (a) to colleagues—in informal discussions, in formal presentations at staff meetings, and, in one instance, at a State meeting for new child welfare workers; (b) to representatives of other governmental agencies such as municipal zoning commissions, with emphasis upon the agencies' common interests and goals; (c) to staff and board members of voluntary family and child-placing agencies, with emphasis upon the protective element in licensing; and (d) to community clubs, civic groups, and high school classes through speeches.

- Work with newspapers to publicize the need for licensing day-care homes and to discourage advertising of unlicensed family day-care homes.

- Participation in radio and television interviews or formal presentations about licensing.

- Participation on community committees set up to deal with various problems related to child welfare functions.

- Participation in formal community surveys of day-care resources.

- Preparation and distribution of informational pamphlets dealing with day care and licensing.

Trainees generally were supported in such community efforts by their agency administrators and supervisors. However, most of these activities came about through the demonstration, rather than as an integral part of an already organized, assertive agency program of community education.

While the question of whether nonprofessional persons can successfully perform the tasks of supervising and consulting with the licensee (supervision-consultation) cannot be answered from our data without some qualification, the scores on the supervisory rating scale indicated that when the trainees carried out such tasks, their performance generally satisfied their agency supervisors. Furthermore, other evaluative measures showed that many trainees successfully performed such tasks in various kinds of case situations, thus reinforcing our conclusion that nonprofessional persons can be taught to perform the tasks of supervision-consultation effectively. Much seemed to depend upon the expectations of the

agency and the trainee's supervisor. Trainees who did not perform such tasks even when the case situation seemed to warrant them usually had had little support from their agency to do so.

It must be pointed out that the full potentialities of nonprofessional persons for carrying out the function of licensing family homes were not measured. Our evaluative procedures did not provide for such complete measurement nor was the agency work setting appropriate for it. There is reason to believe, however, that the potentialities of many of the trainees for performing the tasks under study were higher than the agencies required.

Tasks presenting difficulty

There were some tasks which some trainees did not perform successfully: those involving the use of authority when a home is found to be unsatisfactory; and those required for making an adequate study at a time of relicensing. The project is recommending that nonprofessional workers be given additional training or supervisory help with these tasks as well as with the provision of supervision-consultation to the licensee. The tasks which presented special difficulty to some trainees were: explaining the meaning and purpose of the licensing law to applicants and licensees; acting on their right as representatives of the State to "require" and "prohibit"; tempering an applicant's resistance to licensing; dealing with applicants whose homes are not licensable; insisting that substandard licensees conform with the State's standards; handling complaints; and rejecting a substandard home when relicensing is due.

The findings indicated that the nonprofessional worker's competence in such tasks depended largely on how clear his agency's expectations were about the use of authority and how much opportunity for support and learning the agency provided its entire staff, professional and nonprofessional, in this regard.

The following factors seemed to be related to the trainees' difficulties in carrying out an adequate study at time of relicensing:

- Heavy workloads which often left time for only a brief reappraisal of the home instead of a thorough restudy and the provision of consultation to help the licensee bring the home up to standards.

- The failure of agencies to recognize the potentiality in the relicensing process for improving the quality of care for children.

- The unpleasantness encountered in denying a license renewal to a home once approved for child-care service but no longer meeting the agency's standards.

Tasks involved in working with parents of children in independent placement were performed so infrequently by trainees that their supervisors usually said they had no basis for judging their performance. In spite of the increasing number of parents who place their children independently in day care, there seems to be a general lack of agency activity in relation to them. Yet when trainees did have opportunity to work with such parents, their supervisors were usually satisfied with their performance. These findings suggest certain questions: What *are* the needs of such parents for service? What kind of service can and should be offered to them? Under what auspices should this service be given?

Group comparison

When a comparison was made of the trainees' performance on the job in each of the three training groups, only minor differences appeared. No group stood out as clearly superior to the others in achievement or performance. At first glance, this finding may seem to indicate that the choice of training methods is not important in preparing nonprofessional persons to perform the tasks in licensing family day-care homes. If this were so, then the agency might choose a training plan on the basis of cost, administrative setting, the teaching personnel available, or other practical reasons.

It must be pointed out, however, that these training demonstrations did not illustrate actual differences in *method*. The differences were in *auspices* and *teaching personnel*. Overriding them were important constant factors: the same set of teaching materials, based on an analysis of the function for which training was being given; the same teaching objectives, based on the same theories of teaching and learning; and the same careful presession planning.

The study does not warrant a conclusion that the means of training are unimportant. It does indicate that a variety of means may prove successful, given certain important ingredients, such as useful training materials, clear and consistent teaching objectives, thorough planning, and agency support of the functions for which the training is given. A logical sequel to this project would be to measure the performance of nonprofessionals trained by a program

of self-study, using the same set of training materials and evaluative measures as in this project.

As part of the project's evaluation, questionnaires were sent to trainees, supervisors, and State representatives serving the project in a liaison capacity. A large majority of the respondents rated the training course as very helpful. The most positive statements came from the supervisors' training demonstration—Demonstration III.

In general, the participants gave high ratings to the usefulness, organization, and coverage of the training materials. This would seem to confirm the assumption that training materials for nonprofessional workers can be developed outside the employing agency and can be adapted to the agency's specific procedures, level of practice, and the skills of its available teaching personnel.

The responses also indicated that, where agency conditions are conducive to continued teaching and learning on the job, a training program can strengthen the role of the agency's supervisors and the satisfactions of the supervisor-worker relationship.

Some obstacles

Information from the agencies, as well as the participants, made it obvious that external pressures frequently prevented a trainee from fully using the knowledge he had acquired during the training sessions. One pressure came from the great demand in communities for family day-care homes, a demand which contributed to the incompleteness of home studies or a tendency to compromise with standards. The pressure felt within agencies to keep a home in use for particular children was often very great, particularly when alternative arrangements for the children's care were not visible.

Another obstacle to a trainee's making full use of his training often lay in the agency's hesitation to require conformity to its standards for family day care because of the danger of damaging its "image" in a community where a licensing service was just being initiated. This was particularly true in communities where there had been no program to educate the public about the licensing law.

Still another obstacle was presented by lack of administrative or supervisory backing for denying a license when a denial was indicated. The use of authority was obviously a problem among the professional as well as the nonprofessional staff members of many agencies.

And, in most agencies, heavy workloads always threatened to get in the way of an adequate consideration of all the matters relevant to a decision about issuing or not issuing a license.

School-agency relationships

What has been learned through this project about the feasibility of a cooperative staff development venture between a school of social work and public child welfare agencies?

Certainly, difficulties were encountered along the way. The potential obstacles to successful cooperation usually stemmed from the differences in function and organizational structure of school and agency. These created difficulties in communication, in recruiting States for participation in the project, and in reaching a common understanding of what to expect from the demonstrations. In most instances, these difficulties were dealt with successfully, a fact largely attributable to the high degree of cooperation received from the participating public child welfare agencies.

In spite of its problems, this project has demonstrated that a school of social work and a group of public welfare agencies can move together toward common educational goals and toward effecting a closer relationship between social work education and practice. The school received many expressions of appreciation from agency staff members for the satisfactions realized in this cooperative venture. In turn, the representatives of the school who were on the project staff gained reinforcement for their already close identification with the public child welfare field, as well as new learning that can be used to enrich their teaching efforts in the graduate classroom.

The project clearly demonstrated the effectiveness of school-agency cooperation and the importance of continued communication between the two.

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[1] Costin, Lela B.; Gruener, Jennette R.: A project for training personnel in child welfare. *Child Welfare*, April 1964.

[2] ———: The licensing of family homes in child welfare—a guide for instructors and trainees. Wayne State University Press, Detroit, Mich. 1965.

[3] Educational Testing Service: Examiner's manual: cooperative school and college ability tests. Princeton, N.J. 1955.

[4] Schaefer, E. S.; Bell, R. Q.: Development of a parental attitude research instrument. *Child Development*, September 1958.

[5] Zuckerman, M.; Ribback, B. B.; Monashkin, I.; Norton, J. A.: Normative data and factor analysis on the parental attitude research instrument. *Journal of Consulting Psychology*, June 1958.

SELECTING FOSTER PARENTS for DISTURBED CHILDREN

ANTHONY N. MALUCCIO

Today child welfare agencies the country over are finding that the children who are brought to them for foster family placement are on the whole in greater emotional difficulty than those of the past. This change has resulted in the need for more intensive evaluation of prospective foster parents and their ability to cope constructively with the difficulties presented by a disturbed child.[1-3] It has also resulted in an increasing concern about the effect of such a child's placement on the members of the foster family and on the family balance and integration. Child welfare workers are becoming aware that the placement of a traumatized child may awaken latent conflicts in the foster parents and lead to disruption of their own personal or family life.[4, 5]

What are some of the elements in the placement of a disturbed child which may upset individual or group adjustment within a foster family? And what are their implications for foster parent selection? In exploring these questions, this paper will focus on foster parents for "emotionally disturbed children"—children showing severe distress, maladaptive behavior, or pathological character traits. But much of what it says may be applied, in varying degrees, to all foster parents.

For the ideas presented here, the author is partly indebted to Leonard M. Lasser, M.D., formerly psychiatric consultant, and Alice Y. Moe, director of casework, Children's Village Programs, Children's Services of Connecticut.

Impact of placement

On the child. As a child is placed in a foster home, he is often faced with a crisis in his sense of identity and security which may result in a strong feeling of loss and helplessness. At the same time, being separated from his parents reactivates his unresolved conflicts in regard to them, conflicts which stem from his feelings of deprivation, rejection, or hostility. His reaction in the foster home, therefore, may include angry testing out, depression, emotional detachment, and withdrawal.[6]

Following placement, the child may behave in the same way he would in reacting to his own parents' needs and behavior patterns, instead of reacting

realistically to what the new foster family is offering. Many foster children apparently try to recreate their own family situation in the foster home, probably as a desperate measure against their sense of lost identity and insecurity. As Littner has observed, the child's need to repeat his past constitutes "one of various defense mechanisms he uses for dealing with problems in the present." [7]

The foster family's early efforts to create a positive environment for the child often arouse in him further resentment toward his own parents. It is as if he suddenly becomes aware of everything he has needed in life and has not received through his own parents. The newly aroused anger adds to the strength of the child's longstanding resentment and leads to intensification of his guilt feelings, his sense of rejection, and his self-image as a worthless and unwanted child. All this may stimulate aggressive testing-out behavior, which results in increased anxiety in both the child and the foster parents.

On natural parents. A child's placement in foster care affects different natural parents differently, depending on such factors as their personality structure, the special meaning the child has for them, and the family situation at the time of placement. Some common themes occur, however, in the reactions of parents who continue to see their child after he has been placed. For example, the very fact of placement, in confirming the parents' inability to care for their child, reinforces their sense of inadequacy, failure, and loss. A consequent sense of isolation and an intensified sense of guilt over their hostile feelings toward the child arouse in them further anxiety.

An emotionally disturbed child typically relates to his parents on an infantile level, and he often reacts with rage when his demands for primitive gratification are not met.[8] Following placement in foster care, such a child continues to make demands on his own parents, and their inability to meet his needs intensifies their feelings of guilt and anger. Through their continuing contacts with the child, the parents communicate their anxiety and their conflicting attitudes toward him and the placement, thus contributing to the perpetuation of the child's ambivalent feelings toward them and toward himself. Some parents may inwardly need to sabotage the placement, particularly as they see the foster parents succeeding in building a positive relationship with the child, something they, the child's own parents, had been unable to do.

On the foster family. Thus, a disturbed child brings into his foster placement intense inner turmoil and unresolved conflicts in such areas as aggression, ambivalence, and identification. Furthermore, the child's anger against his own parents is often projected directly onto the foster parents, who are readily accessible as substitute parental figures. Because of the force and variety of the feelings which come into play in such a situation, the introduction of a disturbed foster child into a family can lead to the arousal of the foster parents' unresolved childhood conflicts. At the same time, the coming of a foster child may produce a rapid shift in the family's pattern of living, requiring a degree of strength and flexibility not all families possess. Moreover, the child's aggressive behavior may bring more stress to the foster parents and their children than they can bear.

Another source of anxiety for both foster parents and foster child is their relationship with the agency. The nature of the relationship is conducive to the kind of reaction in the foster parents known in psychiatry as "transference," with the foster parents unconsciously viewing the caseworker as their own parent and the agency as the ultimate parental authority.[9] Moreover, since the emphasis of this relationship is on treatment of the child's disturbance, considerable inward turmoil may have to be aroused in the foster child in order to have personal change and growth occur through the therapeutic process. This, in turn, may arouse turmoil within the foster parents.

Thus, as they take a disturbed child into their home, foster parents are faced with many elements of potential stress. A result often is the arousal of latent personal and family conflicts within the foster home as well as the rewakening of unresolved conflicts from the foster parents' earlier life with their

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own parents. When these conflicts are so severe as to disrupt the foster parents' emotional equilibrium or the foster family's ability to function, a crisis is created which is not always amenable to resolution, even with intensive and skilled casework service. The strain on both child and foster family may then require the child's removal from the home.

Selection of foster parents

A major purpose of a foster home study is to assess the degree of stress which the placement of a child might create in the prospective foster family and the family's capacity for handling this stress with agency help. However, in the current state of our knowledge, this is easier said than done. Nevertheless, there are certain factors which if observed and assessed can be helpful in the process of foster parent selection, though these factors may not by themselves be definitive indicators of the foster parents' capacity for providing the right kind of home for the child nor be applicable in every case.

The first factor needing clarification is the applicants' typical pattern of coping with anxiety, as reflected in their responses to normal as well as unusual crises in their own lives. Applicants can be expected to have difficulty in handling the stress created by a foster child, if their characteristic reaction to anxiety has been denial or withdrawal.

Another factor needing assessment is the foster parents' degree of sensitivity to the feelings and needs of others. If the foster parents have successfully resolved the conflicts in their own experiences, neurotic or otherwise, they may have a heightened awareness of the suffering and anxiety which human beings experience as part of their growth process. Having such an awareness is particularly important for anyone working with a disturbed child.

Prospective foster parents apply for a foster child out of multiple and complex needs of their own. Often they are searching for personal development and for help with the resolution of their conflicts.[5, 10-12] If their coming to the agency seems chiefly a response to a deeply neurotic need—a search for a way of working out severe difficulties of their own—they probably could not be helpful to a foster child and could be overwhelmed by the child's neurotic problems.

In other words, if foster parents have not had a truly creative growth experience in childhood, they will probably not be able to encourage the child to separate himself from the constrictions inherent in his relationship with his own parents. If they do not have the capacity for further growth themselves, they will not be able to tolerate a child's development beyond their own level. When a child is placed with such people, there may ensue an apparently untroubled situation in which the child simply stands still. But if the child strives to move beyond the foster parents' own level of development, a crisis may occur, perhaps leading to rejection and removal of the child from the foster home.

A third factor needing careful examination is the degree to which the prospective foster parents are likely to become emotionally involved with a foster child. Overidentification on the part of foster parents, even if it has a positive motivation, can prevent a child from freely developing his own personality. Foster parents should be able to maintain some emotional distance between themselves and the child. This does not mean that foster parents should not relate closely to a child; it does mean that they should not become so emotionally involved that their own personality becomes enmeshed in the child's character structure and problems. Ideally, the foster parents should be able to give a child what he needs in a way that respects his individuality and promotes his growth, instead of encouraging him to become an extension of themselves. In short, prospective foster parents must demonstrate that their psychological separation from their own parents is sufficiently strong to allow them to stimulate the foster child to develop as a separate person.

The following example illustrates the importance of the foster parents' capacity for growth within themselves and their ability to tolerate growth in the foster child.

Mr. and Mrs. A were a stable couple in their early fifties, who had had no children of their own. Both came from large families and had helped to rear several of their nephews and nieces and thus had achieved some satisfaction as substitute parents. They had always been afraid of close involvement with a child, however, and had never applied for adoption.

Their interest in becoming foster parents was stimulated by their having lost close contact with their many nieces and nephews because they had moved to another town. During the home study, Mr. and Mrs. A related comfortably with the agency's worker and showed their eagerness to give loving care to a child.

Judy, the child placed with them, was an immature and disorganized adolescent who had been diagnosed as a borderline schizophrenic. Since babyhood she had lived with a series of foster parents, none of whom could tolerate her immature and bizarre behavior.

Before being placed with the A's, Judy had entered into psychiatric treatment. Following placement, treatment

progressed steadily, as Judy began to pour out her feelings and to move into direct self-exploration. At the same time, she made marked demands on the A's, through angry testing out, open belligerence, and with Mr. A, the type of seductive behavior characteristic of early adolescence. She seemed to be suddenly and urgently struggling to grow.

The A's were upset by Judy's demands, but they expressed their anxiety about these new experiences to the caseworker and thus reached out for the agency's help. This helped them to avoid responding in a personal way to Judy's testing out and to allow her to express her feelings.

As a result of her therapy as well as her positive experience with the A's, Judy, in less than a year, made significant strides toward emotional security, which were reflected in improved social and academic functioning. Simultaneously, while going through a distressing experience, the A's effected changes within themselves—as evidenced by increased self-awareness, better self-image, and sense of fulfillment as parents.

Thus, the outcome of a placement can depend on the foster parents' capacity for being stimulated by anxiety to further personal growth as well as on their readiness to encourage the child's own efforts to grow. A decisive factor can be the foster parents' ability to use casework services.

A further factor to be assessed in evaluating a potential foster home is the degree of the applicants' inner security. They should possess enough security to allow the agency's worker to get to know them intimately, with all their liabilities and assets; to determine whether their needs, both healthy and neurotic, will best be met by caring for a foster child and, if so, what kind of a foster child; and to judge their capacity for reaching out for appropriate help when needed.

Assessment of family strength

In addition to an evaluation of the prospective foster parents' personality structure, the home study should include an assessment of family strengths and dynamics.[13] An assumption that, since the foster parents' own children have grown up successfully, the foster child will do likewise in the same home can be erroneous. In a normal family, the family dynamics are oriented toward child and parents accommodating themselves to each other's needs over a long period of time; the foster child, in contrast, has not had this opportunity. As Kline and Overstreet have pointed out, "in the majority of cases . . . he has learned disturbed and disturbing ways of relating to the world around him to maintain his psychological equilibrium."[9]

Because the introduction of a foster child may seriously affect family relationships, it is important to determine whether the family structure is healthy enough to withstand the additional pressures of a disturbed child. If there is considerable actual or potential family pathology, the foster child may become the focus of hostility and anxiety.

Sometimes, for example, the foster parents' latent anxiety about their own child emerges when they receive a foster child, and so much anxiety is engendered that the foster parents finally request removal of the foster child. The marital relationship of the foster parents must contain sufficient gratification so that neither partner is threatened by the foster child and neither uses the child to fill needs which more properly should be filled by the other. Thus an assessment should be made of the quality of the applicants' marital relationship and the implications of their request for a foster child.

Mr. and Mrs. B were in their late twenties when they applied to become foster parents. They wanted children of their own and had been married several years, but Mrs. B had been unable to conceive.

Mr. B was the oldest of several children of an alcoholic father and an emotionally distant mother. A successful businessman with a quiet, reserved manner, he, nevertheless, revealed some indications of a warm and secure personality.

Mrs. B was the youngest child of parents who had given her much materially but little emotionally. An outgoing, demonstrative woman, she returned her husband's respect. However, she showed some signs of receiving insufficient emotional gratification from the marriage.

George, the foster child placed with the B's, was a disorganized and infantile 9-year-old. During his first 2 years with the B's, Mrs. B met his infantile needs so effectively that George slowly began to grow emotionally. As she became more involved with George, Mrs. B became less attentive to her husband. Her own needs were to a large extent met through the boy, who developed into a responsive and rewarding youngster.

The B's invested a great deal of effort in helping George and in working with the agency. But as he grew into adolescence, the boy's needs changed and the foster parents found it harder to work with him. The resulting strain had a deteriorating effect on the couple's marital relationship. Mrs. B complained to her husband that George was a demanding child requiring all her time; she told George that her husband was an inadequate, selfish man. Mr. B withdrew further from his wife, and her sense of dissatisfaction and feeling of being rejected by him were thereby intensified. George began to regress.

When the first signs of deterioration in the B's marital relationship appeared, the agency offered to provide them with marital counseling, either directly or through other resources; but each maintained that there would be no difficulty if the other changed. In casework sessions, the B's were unable to look at what was happening in their relationship. Mrs. B blamed her husband for not being interested in her, while he

complained that she was greatly exaggerating the situation.

When, after several months, the B's were still unable to effect any changes in their relationship, the agency decided to remove George from their home. There was no doubt about George's having progressed through living in the B's home. However, in view of his stage of development and the B's marital tension, the agency concluded that his continued placement with them would not be beneficial to either George or the B's.

Following his placement in the home of a more mature and stable couple, George showed surprising ability to work through some of his adolescent struggles and to form more positive relationships with both his foster father and foster mother.

In the foregoing example, the foster parents' latent marital difficulties apparently were activated and reinforced through the introduction of a child from whom the foster mother could gain gratification while driving her husband further away from her. A more thorough evaluation of the foster parents' marital relationship, with all its subtleties, might have resulted in the placement of a less demanding child and the provision of more effective casework help prior to the development of serious marital discord.

Tools and techniques

The complex process of selecting foster parents for emotionally disturbed children may require, in addition to the usual home study by a social worker, use of the diagnostic skills of other professional persons—specifically a psychologist and a psychiatrist. Having the prospective foster parents interviewed by a psychiatric consultant can be especially helpful, for, in addition to providing information about the applicants' emotional needs, the psychiatrist can appraise their ability to cope with anxiety-provoking situations.

In every instance, an imaginative, individualized approach is called for. New tools and techniques may also be needed. Perhaps there can be further refinement of useful psychological instruments, such as the sentence completion test described by Colvin.[14]

Experience has shown that discussion of each prospective foster family in a multidisciplinary staff conference can lead to a more unified, objective, and intensive understanding of the applicants. Such a discussion can help the caseworker arrive at an earlier identification of grossly unsuited applicants, move more confidently through the process of gathering and evaluating pertinent information, gain conviction regarding the importance of going into intimate material with prospective foster parents, and recognize the transference and countertransference reactions which may develop during the home study.

The process of evaluating foster parents must not end at the conclusion of the study. On the contrary, there should be a continuing evaluation of each foster family's strengths and weaknesses in relation to their specific foster child as long as the child is in their home. The following example illustrates the importance of being aware of any new element which may make a foster family more vulnerable to stress.

Mr. and Mrs. C have worked with the agency as foster parents for 10 years, caring successfully for several emotionally disturbed foster children. Mary, their own 6-year-old daughter, an only child, has been very slow in her mental and physical development. Until recently, the C's have attributed the slowness of her development to the fact that she has a congenital heart malformation. But when Mary entered school and her limitations became more obvious, leading her principal to suggest that she be taken to a child guidance clinic, the C's equanimity was severely upset.

For the first time, the C's were forced to face Mary's problems. Their initial reaction was to project their feelings of being threatened onto their foster child, an aggressive 10-year-old boy. Although they had previously demonstrated unusual capacity for giving loving care to this seriously disturbed child and to tolerate his behavior, they suddenly had a great deal of difficulty coping with him. Wondering if he were not causing some of their daughter's problems, they began to consider requesting his removal from their home.

The caseworker intensified his support of the C's, and when they in turn reached out for further help, he encouraged them to discuss their own child's problems with him and with the psychiatrist. As the C's began to gain some insight into their ambivalent feelings toward Mary through these discussions, their anxiety was alleviated and they were able to accept a referral to a child guidance clinic. At the same time, they felt less threatened by the behaviour of the foster child, whom they again were able to handle with objectivity and competence.

Thus, by providing intensified service to a foster family at a time of vulnerability, the agency was able to help the foster parents successfully surmount a crisis without removal of the foster child. In this process, there occurred a strengthening of their roles as foster parents and a deepening of their relationship with the agency.

In conclusion

Further study is necessary to refine and validate many of the ideas expressed here. But there can be no question about the need to *know* prospective foster parents in considerable depth. This article has stressed the implications of certain pathological needs. Equally important, however, as criteria for

judging the capacity of foster parents for caring for a disturbed child are the healthy aspects of their personalities and the positive features of their request for a child.

The writer and his colleagues believe that some of the most important criteria in foster parent selection are: (1) The applicants' ability to cope with anxiety and to utilize it constructively; (2) their readiness to tolerate the need for personal growth within themselves and to permit the child to develop as fully and freely as possible; (3) their ability to avoid identifying the child too closely with experiences in their own past; and (4) their ability to use casework services.

We also believe that, as various authors have pointed out, selection of the most appropriate child for a foster home can be crucial to the success of the placement.[1, 3] Such selection is based not only on a full understanding of the foster family but also on a thorough evaluation of the child.

Our experience has convinced us that it is possible to help certain emotionally disturbed children effectively through placement in foster homes. We recognize that at times such efforts can be frustrating and lead to serious questions about the use of foster family care for disturbed children.[15, 16] We can only reiterate the confidence we have already expressed in the many families in our program who have exhibited sufficient strength to withstand the pressures of living with an emotionally disturbed foster child and to give an effective service.[17] At the same time, we fully realize that the success of any placement is to a large extent dependent on the quality and quantity of services available to the child, to the natural parents, and to the foster parents.

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[1] Bohman, L. John: Methods of recruiting foster homes and ways to enable foster parents to help the children. *Child Welfare,* December 1957.

[2] Mora, George: Foster families for emotionally disturbed children. *Child Welfare,* March 1962.

[3] Wagner, Nathaniel N.: Clinical evaluation of foster parents. *Child Welfare,* March 1962.

[4] Kline, Draza: Understanding and evaluating a foster family's capacity to meet the needs of an individual child. *In* Changing needs and practices in child welfare. Child Welfare League of America, New York. 1960.

[5] Lawder, Elizabeth A.: Toward a more scientific understanding of foster family care. *Child Welfare,* February 1964.

[6] Littner, Ner: Some traumatic effects of separation and placement. Child Welfare League of America, New York. 1956.

[7] ———: The child's need to repeat his past: some implications for placement. *In* Changing needs and practices in child welfare. Child Welfare League of America, New York. 1960.

[8] Mandelbaum, Arthur: Parent-child separation: its significance to parents. *Social Work,* October 1962.

[9] Kline, Draza; Overstreet, Helen M.: Casework with foster parents. Child Welfare League of America, New York. 1956.

[10] Josselyn, Irene: Evaluating motives of foster parents. *Child Welfare,* February 1952.

[11] Mintz, Ira L.: Multidetermined motivations in foster parents. *Child Welfare,* April 1962.

[12] McCoy, Jacqueline: The motives and conflicts in foster parenthood, *Children,* November–December 1962.

[13] Kinter, Richard; Otto, Herbert A.: The family-strength concept and foster family selection. *Child Welfare,* July 1964.

[14] Colvin, Ralph W.: Toward the development of a foster parent attitude test. *In* Quantitative approaches to parent selection. Child Welfare League of America, New York. 1962.

[15] De Fries, Zira; Jenkins, Shirley; Williams, Ethelyn C.: Treatment of disturbed children in foster care. *American Journal of Orthopsychiatry,* July 1964.

[16] ———: Foster family care for disturbed children—a nonsentimental view. *Child Welfare,* February 1965.

[17] Moe, Alice Y.: Discussion of foster family care for disturbed children—a nonsentimental view. *Child Welfare,* February 1965.

Healing hurt children through foster parenting is a vital social good—a necessity for many children and a necessity for a responsible public. It should not be limited by a notion that the foster parent should martyr himself to the job. The public should pay for foster care in terms of the effort and skill it requires.

Thomas M. Parham, Director, Division for Children and Youth, Georgia Department of Family and Children Services, to a 1965 alumni meeting of the University of Tennessee School of Social Work.

a report from abroad . . .

FAMILY AND CHILD WELFARE IN SOUTH VIETNAM

ELISABETH SHIRLEY ENOCHS

A strong sense of family unity and a capacity for self-help may be chief factors in sustaining the basic human values in thousands of Vietnamese families and children who have been uprooted from their homes by the exigencies of war. This impression, gained by the writer in a 2-week visit to South Vietnam last September, for the Agency for International Development (AID), U.S. Department of State, was strengthened by the report of a seven-man team, representative of American voluntary relief agencies, sent to Vietnam by AID in October. Both missions were undertaken as the result of a growing concern in this country about the welfare of the large numbers of children among the refugees, and the fear that Vietnam's need to provide care for war orphans might result in an increasing reliance on the institutional care of children.

It is difficult for people in the United States to grasp the extreme complexity of life in South Vietnam. The country has been at war for more than 20 years. At the same time, it has been trying to build or strengthen the basic institutions of a newly independent country. During the last decade, it has also had to resettle and absorb about a million refugees from North Vietnam. It has also had to deal with internal dissension, revolution, religious strife, and the constant need to move large numbers of rural people to urban centers or coastal regions because of the military situation.

Although it has never taken a census, the Government of Vietnam in 1962 estimated that more than half the population was under 20 years of age; that more than 81 percent lived in rural areas.

The refugees

Approximately 400,000 persons were living in refugee camps at the end of 1965—about 60 percent of them were children, 30 percent, women, and the remainder, aged or incapacitated men.

Not all the refugees are living in refugee camps—many have been taken in by relatives. Nor are all refugees fugitives from zones of combat. Because there is no dependents' allowance alloted to the families of Vietnamese conscripts, the wives and children of servicemen follow their menfolk from place to place. Also, many of today's "refugees" are victims of disastrous floods, still unable to return to their homes. On the other hand, attachment to one's own communities and the tombs of one's ancestors is so great in Vietnam that even the people who have fled from Viet Cong terrorism or from military activity try to return home as soon as they believe some security prevails.

Many refugees find employment on their own initiative. Small family industries appear. Many bring with them their simple tools and endeavor to ply their trades in the new location.

Noting "repeated evidences of strong family ties among the refugees," the AID-sponsored team reported:

> . . . [the] refugees invariably moved in family, village, and hamlet groups with recognized leadership that had authority in the camps and were an effective channel for assistance. Individual families and groups were frequently taken in by relatives in secure areas. Those in camps were observed cooking their own food and building their own huts.

Basic responsibility for care of the refugees rests with the Ministry of Social Action which provides an allowance of 7 piastres per day to adults (not quite 10 cents a day at the official rate of exchange), with an additional allowance in cash or in kind, usually condensed milk, for children under 2. The provision of condensed milk represents something of an innovation in infant feeding in Vietnam, where it has been customary among many rural families to breast feed children until they are 15 to 24, or even 36, months old.

The rural population of South Vietnam lives under conditions so primitive that the change to refugee status may represent less material hardship for many families than might be imagined. While recognizing the vast needs of many Vietnamese who have not been torn from their homes, the AID mission and a number of voluntary agencies are working with the Vietnamese Government to help these refugees preserve their strong family ties and native resourcefulness and to encourage their ability for leadership.

When I asked officials of the Ministry of Social Action what they needed the most, they mentioned four materials: (1) cement; (2) roofing; (3) calico; (4) *nuoc mam* (a widely used oily sauce extracted from fish). Cor-

In a refugee camp in South Vietnam.

rugated metal roofing is used for refugee housing, since part of the harassment of the Viet Cong has consisted of burning the vegetation used for the customary thatched roofs.

Education and training

On the nonmaterial side, the officials gave first priority to training opportunities for all categories of service personnel: doctors, nurses, teachers, social workers, midwives. Second was the need for more schools and for vocational training facilities.

The Government reports that it allots about 15 percent of its total budget to education and vocational training. Additional support for education is derived from foreign aid. According to estimates of the Ministry of Education, 65 percent of the children of school age in Vietnam enter school. About 40 percent finish primary school.

The director of the education division of the AID mission in South Vietnam tells a story that illustrates the Vietnamese determination not to let the war disrupt the educational opportunities of children. When military activity in the interior caused 11,000 people to be moved to a coastal region, almost the first question raised was, "What about schools for the children?" Someone designed a shed for use as an emergency classroom. Someone else designed a more permanent type of structure. While the merits of the two designs were being studied, the local authorities in the region of resettlement had been busy making a survey of other possibilities. As a result, all existing schools in the locality, both public and private, were asked to take in as many refugee children as possible. Some additional buildings were located which could be adapted for classroom use. Only a very few emergency structures had to be built.

However, in some areas the local schools have not been so receptive to refugee children, particularly if they are from montagnard families.

Recognized dangers

Deep concern about the Vietnamese younger generation is reflected in a report prepared by various Vietnamese Government agencies for the Asian Conference on Children and Youth, scheduled to meet in Bangkok, Thailand, in March 1966, under the auspices of the United Nations Children's Fund (UNICEF), the Economic Commission for Asia and the Far East (ECAFE), and the Asian Institute for Economic Development and Planning. It says:

> . . . The victims of battle leave behind them a steadily increasing number of orphans. In spite of the understanding shown by the authorities, government action to help these orphans becomes more and more inadequate as the military operations continue. Because of this the number of juvenile delinquents seems to be growing daily.
>
> Moreover, the moral health of the country is severely impaired by the war which is being conducted in the countryside. Young people are confined to the towns where, idle and jobless, they have nothing to do with their time; bars and cafes are full and, as a result, rowdyism becomes proportionately more widespread. They should be given a worthwhile occupation to free them from the war psychosis they have lived in all their lives. Their morale should be improved and they should be given a sense of citizenship through education.

Vietnamese officials are especially worried about the "cowboys," by which they mean juvenile delinquents. They hope for the establishment of social centers and neighborhood houses where youth activities and adult education programs may be conducted. One such center was recently opened in a Saigon slum by the school of social work sponsored by the Vietnamese Catholic agency, Caritas.

Child care

The United Nations has assigned a child welfare consultant to cooperate with the Ministry of Social Action in planning for children and youth, who has established a model day-care center in Saigon. The Government plans to establish 348 like it in Saigon and in the provinces, with the hope of obviating the placement of young children in institutions. Many of the babies and young children now residing in Vietnamese orphanages have been brought to them by working mothers with large families who cannot remain employed if they have to take care of an additional child.

The Government also has plans to establish five orphanages. There are already over 70 orphanages in South Vietnam, 5 or 6 of them sponsored by Buddhist groups, and the rest mainly by Catholic organizations. Many of these institutions date back to the days of the French.

The orphanage at Than Duc, in Long An Province, which I visited, is said to be typical. Located in the heart of the village, it shelters 66 girls and 53 boys, ranging in age from a few months to 16 years. It is run by four nuns belonging to a Vietnamese sisterhood. They are assisted by 10 lay helpers. The older children attend the village school; the younger, classes in the institution.

This institution is over 30 years old. The Bishop of Saigon contributes 5,000 piastres ($60) monthly to its support. The Ministry of Social Action provides 1,500 piastres a month ($21) and the American agency, Catholic Relief Services, contributes monthly 15 bags of flour, 25 bags of wheat, 5 cases of cooking oil, 8 bags of corn meal, and 5 cases of dried milk. Each month the nuns buy 240 kilos of Vietnamese rice. With the children's help, they raise pigs, ducks, chickens, and vegetables.

The institution contained only a few children who are actual war orphans. The mother superior said the children fell into three categories: (1) the "social cases"—children of very poor families where the father is dead or absent and the mother, with many children,

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finds it impossible to work and care for them all; (2) the "fatherless"—illegitimate children; and (3) the "true orphans." She said that children in the first category are not completely separated from their families. Their mothers continue to visit them. When the children reach working age, the mother or some other relative usually appears to claim them. Other children are helped to find employment when they leave the institution at the age of 16.

In Than Duc, as in other institutions I visited, there was an unusually large proportion of children with physical defects such as hare lip, cleft palate, and club foot. The nuns said that in Vietnam such children are thought to bring bad luck and are therefore abandoned at birth to protect the rest of the family. Children are also abandoned if they are born on a day of "ill omen."

Another orphanage near Saigon, run by the same religious order, was caring for 721 children at the time of my visit. This institution was greatly overcrowded because it had admitted many children whose families had crowded into Saigon in search of work and security and lacked living space for their large broods. Recent reports indicate that AID has helped to enlarge the institution's plant.

Inquiries about the possibilities of adopting war orphans have come to the Government from Australia, but the Vietnamese do not look with favor on international adoptions, and adoptions are not easy under existing legislation. Thus far the number of war orphans in children's institutions is small.

Efforts are being made to improve standards of institutional care. The United Nations consultant recently conducted an inservice training course for institutional personnel in cooperation with the director of the school of social work in Saigon.

When I asked officials of the Ministry of Social Action whether consideration might be given to substitutes for institutional care, they replied that foster care, if defined as the care of children in families other than their own or in those of relatives, is alien to the cultural patterns of the Vietnamese people. Many families are already caring for many of their kinfolk, and have no room for more, especially with the rising cost of living.

Nevertheless, an impressive demonstration in keeping children out of institutions is being made by Foster Parents Plan, one of the voluntary agencies in Vietnam. This agency concentrates on helping families keep their children at home rather than on child placement. Its director reports that the agency has been helping nearly 5,000 families in Saigon and nearby Cholon and plans on extending the work to the provinces. Through a financial sponsorship system, whereby friends of the agency are asked to support specific families, children are kept with their mothers or relatives and casework services are provided the family by graduate Vietnamese social workers.

International aid

In addition to the United Nations, many international social and health agencies are active in South Vietnam. UNICEF has equipped the first well-baby clinic, in Saigon. From the Philippines have come medical teams. The work of the voluntary agency, Foster Parents Plan, has already been mentioned. This agency has also helped the Vietnamese Women's Association set up an emergency shelter in Saigon for victims of the battle of Dong Xoai.

In addition, 17 U.S. voluntary agencies are now working in South Vietnam. Some of them are distributing commodities under the U.S. Food for Peace program. CARE is helping to increase the supply of *nuoc mam*. Some agencies are providing medical care and related services. Catholic Relief Services, for example, has established a small center in Saigon for the care of crippled children, chiefly polio victims. Some agencies—especially the Mennonite Central Committee, the Church World Service, and the Lutheran World Relief—are engaged in health and educational programs. The International Voluntary Services is helping with community development.

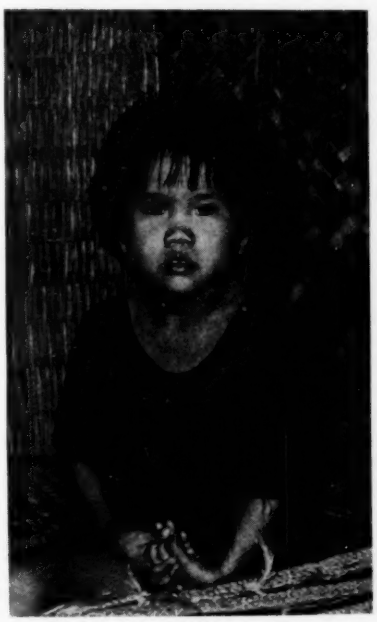
AID has established a refugee unit in its Washington office and one in Vietnam and recently recruited a specialist in child welfare to work in Saigon. Many of the voluntary agencies are also increasing staff, to meet a need underscored in the report of the team that visited Vietnam last October:

> On all sides in Vietnam, we found pleas for more personnel in a wide variety of qualifications for work with refugees. Food, material, and transportation problems are present, to be sure. But these appeared manageable. What was sought, however, was additional people stationed in the field . . . to provide personal, individual services in widely scattered camps, cities, and villages covering the whole range of welfare activities for people in acute need . . . . These were requested unhesitatingly by Vietnamese government officials, by U.S. civil and military officers, and by the voluntary agency groups themselves.

Graduates of the school of social work in Saigon, operated by Caritas, are in great demand in both public and voluntary agencies. Founded in 1949 under Catholic auspices, the school has 45 students, all women, most of whom are Buddhists. A second school of social work, emphasizing community development, opened in August 1965 in the Buddhist University, with an enrollment of 250 students of both sexes.

Thus in combined efforts many agencies, national and international, public and private, are cooperating with the Government and people of South Vietnam to contribute to the welfare of Vietnamese families and children. But the greatest hope for the children's future may well lie in the strong sense of family unity and the capacity for self-help which have survived all the upheavals of the last 20 years.

A refugee child in South Vietnam.



HERE and THERE

Infant mortality

The infant mortality rate for the United States in 1964 fell to the lowest level on record, according to data gathered by the National Center for Health Statistics. In 1964 the rate was 24.8 deaths for infants under 1 year of age per 1,000 live births, a decrease of 2.7 percent from the average annual rate for the years 1960–62 and a reduction of 15 percent since 1950, when the rate was 29.2.

A Children's Bureau analysis of the 1964 rates shows that though the reduction in rate was significant for both white and nonwhite infants, the reduction for nonwhite infants was smaller. The pace of reduction in the rate for nonwhite infants since the period 1960–62 was —1.7 percent (from 41.8, the annual average rate in the years 1960–62, to 41.1 in 1964), as compared with a 4.4-percent reduction for white infants (from 22.6 to 21.6). Thus, in 1964 the rate for nonwhite infants was 90 percent higher than the rate for white infants as compared with 85 percent higher in the period 1960–62. In 1950, the infant mortality rate for the nonwhite group was 66 percent higher than for whites.

In 1964 the lag in reducing infant mortality for nonwhite infants was principally in the first month of life. The neonatal death rate showed no improvement for nonwhite infants, but rather an indication of increase (0.4 percent—from 26.4 deaths of infants under 28 days old per 1,000 live births in the period 1960–62, to 26.5 in 1964). The 1964 neonatal mortality rate for nonwhite infants was about 64 percent in excess of the rate for whites.

The overall postneonatal rate for infants 1 to 11 months old was reduced by 2.8 percent (from 7.1 in the period 1960–62 to 6.9 in 1964). Here the decrease was somewhat larger for nonwhite infants (—5.2 percent) than for white (—1.8 percent). Nevertheless, the postneonatal rate for nonwhite infants in 1964 exceeded the rate for white infants by 170 percent (14.6 per 1,000 as compared with 5.4 percent).

In considering fetal mortality and infant mortality together, the change in mortality rate in 1964 from the beginning of the perinatal period to the first birthday was slight, 40.5 fetal and infant deaths per 1,000 total births (live and still)—a 1-percent reduction from the period 1960–62, when the joint rate was 40.9.

The small drop in the joint fetal and infant death rate reflects a stationary—perhaps even an increasing—rate among nonwhite infants. For the white infants alone the reduction since 1960–62 was 2.8 percent. In 1964 the joint rate for white infants was about half the rate for nonwhite infants (35.1 per 1,000 total births in contrast to 67.4 among nonwhite infants).

Infant mortality rates by States ranged from 19.8 per 1,000 live births in Massachusetts to 39.4 in Mississippi. Fifteen States decreased significantly their infant mortality rates in 1964 over the average annual rates for 1960–62; 36 States had more or less stationary rates.

In cities which had populations of 500,000 or more in 1960, considered as a group, the infant mortality rate for 1964 was above national average: 27.9 in cities as compared with 24.8 for the country at large. The excess in the large city rate over the national rate was partly due to a higher death rate among white infants in the cities as compared with the national average for white infants. For nonwhite infants in large cities, the rate—39.5—was below the national average for nonwhites—41.1. The infant mortality rate in these major cities rose 4.1 percent in 1964 from the rate in 1963 (27.9 as compared with 26.8). The principal increase was among nonwhite infants, for whom the rise was 7.6 percent (from 36.7 to 39.5).

—Eleanor P. Hunt

Family planning

Late in January, Secretary John W. Gardner enunciated a policy for the Department of Health, Education, and Welfare on population dynamics, fertility, sterility, and family planning designed to "improve the health of the people, to strengthen the integrity of the family and to provide families the freedom of choice to determine the spacing of their children and the size of their families."

As outlined in a memorandum to the heads of the Department's operating agencies, the policy is "to conduct and support programs of basic and applied research . . .; to conduct and support training programs; to collect and make available such data as may be necessary to support, on request, health programs making family planning information and services available; and to provide family planning information and services, on request, to individuals who receive health services from operating agencies of the Department."

While under the policy, State and local agencies are to be informed of the availability of funds for such programs, no pressure is to be put on them to participate nor is pressure "of mind or conscience" to be put on persons served by the programs supported or conducted by the Department.

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Five nurses and midwives in key positions in Brazil, Guatemala, Liberia, Peru, and Uganda in mid-December completed a 3-month program of study in maternal and child health and family planning, developed by the Children's Bureau under a grant from the Agency for International Development (AID) for foreign participants, the first of a projected series.

The program developed out of requests from the governments of the five countries to AID missions for special

training programs for nurses and midwives who would eventually work in family planning services.

The first 4 weeks of the course, which concentrated on family planning, were also attended by nine U.S. nurses responsible for nursing in maternal and child health programs at State, county, or municipal levels of government.

The major part of the program was held at the Graduate School of Nursing of the New York Medical College. Other agencies and institutions which participated in the program included the Planned Parenthood-World Population Federation, the Population Council, the Ford Foundation, the National Council of the Churches of Christ in the U.S.A., the rhythm clinic of the St. Vincent's Hospital in New York, the New York City Health Department, the New York Hospital-Cornell University School of Nursing, the Pan American Health Organization, and the United Nations Food and Agriculture Organization.

The program began for the foreign participants with orientation at Washington's International Center and concluded with a seminar on the communication of skills and ideas, held at Michigan State University, both sponsored by AID.

The program had six major objectives:

1. To bring up to date the participant's knowledge and understanding of the biology and physiology of human reproduction.

2. To identify the role of the nurse in family planning.

3. To examine attitudes toward and the problems of population control and growth.

4. To provide opportunities for clinical observation of contraceptive methods.

5. To review human nutritional needs, especially those of pregnant and nursing mothers and of preschool children. To this end, the program included a seminar on the nutritional needs of mothers and children around the world.

6. To review the use of patient and family health service records and biostatistical data to improve the care given individual patients and families and to plan ways of meeting existing and new health needs. Data on the fundamental health needs of each country represented, brought to the program by each participant, were used as a basis for developing discussions.

Using the first program as a guide, a second program for nurses from Turkey is being planned at that country's request for the summer of 1966.

For youth

Two years of experience with STAMP (Student Tutoring and Motivation of Parents), a project of help for neighborhood high school students and their parents, have led the Carver Community Center of Schenectady, N.Y., its sponsor, to plan to extend the project from a few selected students and their parents to all students and their parents in the neighborhood who want help. For several years before setting up STAMP, according to Mrs. Charles Allen, project supervisor, the Carver Community Center had sponsored a program of individual tutoring for students without notable success. Project STAMP grew out of the belief of workers at the center that lack of motivation at home was responsible in many cases for the failure of tutoring.

In conducting STAMP, the center selected 20 students at random from the seventh, eighth, and ninth grades of one school, all with IQ's in the normal range and poor reading scores. Half took part in the experiment; the other half acted as a control group.

Student in both groups received individual tutoring in two subjects by volunteer tutors, all of whom were college graduates. The difference was that the parents of the students in the experimental group were brought into the project.

STAMP's supervisor visited the families of the students in the experimental group at least every other week. Parents—usually only the mothers—attended group meetings twice a month. As the project progressed, the emphasis of the group meetings was on extending the mothers' horizons, both educationally and culturally, rather than on having the programs predominantly centered on the child. The success of including attendance at a play in the first year's program led to the inclusion of other cultural activities such as opera and a concert in the second year's.

At the end of 2 years, the project worker found that the grades of the students in the project had improved more than those in the control group. In evaluating the project at the end of each year, the mothers said that the project had been helpful and that they believed their children had enjoyed taking part.

The project had other positive results, too, according to Mrs. Allen. In working with the parents, workers found that nearly all families needed social services of some kind. Many serious problems kept the parents from helping their children. Whenever possible, the project worker referred families to agencies that could help them.

The project has been financed by the Junior League of Schenectady and the New York State Division for Youth.

Child welfare

A review schedule for evaluating the intake process in child welfare services, prepared by the Children's Bureau, has recently been distributed to State child welfare agencies. The purpose of the schedule is to help public welfare agencies conduct systematic reviews of the intake process in child welfare cases, in order to improve their services.

The schedule defines "intake process" as all activities—including emergency service, social study, and diagnosis—for a child, from the time the child is brought to the agency's attention to the selection of a plan for service, whether protective services, other services for children in their own homes, services for unmarried parents, adoption, foster family care, group or institutional care, day care, or homemaker service. The intake process is particularly important, according to the instructions accompanying the schedule, because the decision made at the time of these activities affect all subsequent service.

The Bureau, which is working through its regional staff to help State public child welfare agencies apply the schedule during this introductory year, is recommending that it be used in a limited number of localities before being applied in statewide reviews.

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The Extension Division of the University of Wisconsin has completed the preparation of guide material for a 17-week correspondence-discussion course designed to train child-care workers at children's institutions. Discussion leaders, to be selected from different regions throughout the United States,

will give the course under the close supervision of the university. The course consists of 2-hour discussions each week, written assignments, and required reading.

The project to develop guides for the instructor and materials for the child-care workers has received financial support from the Hecht-Parents' Magazine Foundation for Child Welfare, Inc., with the endorsement of the Children's Bureau. The Bureau will soon be working with State licensing agencies, national organizations, schools of social work, and universities to plan for and test the correspondence course.

Children's institutions

The most nearly complete, inclusive, and up-to-date listing of residential institutions for children in the United States has been compiled by the Center for Urban Studies of the University of Chicago for use in its current research on the adequacy of present physical facilities for group care of children. Shirley A. Star is director of the study, which has received a Federal child welfare research grant from the Children's Bureau.

Each State was asked to report every separate facility providing residential care for 6 or more persons under 21 but only for persons under 21. Medical facilities for acute or short-term care, summer camps, and purely educational boarding schools were not included.

Under these definitions, 3,763 institutions and group homes for children were listed in September 1965. Forty percent (1,515) of these were classified as institutions for dependent and neglected children, including temporary shelters. Other categories, in order of number of listings, were residential facilities for mentally retarded children (701, or 19 percent); institutions or detention homes for delinquent children (647, or 17 percent); residential facilities for physically handicapped children (373, or 10 percent), and for emotionally disturbed children (315, or 8 percent); and maternity homes for unmarried girls (212, or 6 percent).

Nearly all the detention facilities, 80 percent of the psychiatric inpatient facilities for children, 69 percent of the institutions for delinquent children, and 55 percent of the temporary shelters were under public auspices. On the other hand, nearly all the maternity homes, 85 percent of the residential treatment centers for emotionally disturbed children, and 78 percent of the institutions for dependent children were under voluntary auspices.

Of 562 group care facilities classified as proprietary, 74 percent were for mentally retarded children. The majority of the latter were in California. Sixty percent of all facilities for retarded children were under proprietary auspices, 22 percent under public auspices, and 18 percent, voluntary.

Cuban children

A total of 258 of the 1,500 Cuban children who on December 1, 1965, were in foster care under the U.S. program for unaccompanied Cuban children were reunited with their parents during the first 10 weeks of the airlift provided by the U.S. Government for would-be Cuban emigrés under agreement with the Cuban Government. Many of the reunions were made possible by the decision, announced by President Johnson last October, that first priority in the airlift program would be given to parents of Cuban children already in this country. As a result, the airlifts through February 10 brought 442 parents—177 couples and 88 lone parents—of 338 of the children in the foster-care program.

Because during the period a few other children were discharged to relatives and friends or were dropped from the program having reached the age of 19, the program had only 1,319 children in care as of February 1. Since the airlifts were taking place at a rate of two a day, an accelerated reduction was anticipated. Plans are to return all children whose parents reach this country to their parents as soon as appropriate arrangements can be made.

At least 13,000 children are known to have come to this country unaccompanied by either parent since late 1960—most of them sent by their parents. Of these, nearly 8,000 have received foster care, arranged by a variety of voluntary agencies, under the Federal program for unaccompanied Cuban refugee children. The program, which was inaugurated early in 1961, is a part of the Cuban Refugee Program of the Department of Health, Education, and Welfare and is administered by the Children's Bureau through the Florida State Department of Public Welfare. (See "Cuban Children Away from Home" by Kathryn Close, CHILDREN, January-February 1963.)

Education

In the fall of 1965, public elementary and secondary schools enrolled 42.1 million children, an increase of 727,000 or 1.8 percent over the previous fall, according to the 1965 statistical survey of public schools made by the U.S. Office of Education. The increase was greater in secondary than in elementary schools. The 15.7 million pupils enrolled in secondary schools in the fall of 1965 represented an increase of 533,000 over the previous fall; the 26.4 million pupils enrolled in elementary schools represented an increase of 194,000.

The survey also showed that the supply of public school teachers increased by 4.1 percent, rising from 1,648,000 to 1,716,000, decreasing the ratio of pupils to teachers from 25.1 to 24.6. The number of teachers with substandard certificates, 81,748, represented a slight decline from the previous year.

The Office of Education estimates that the total expenditures for public schools in the current school year (1965–66) will be about $25.8 billion.

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With the exception of one institution in Mississippi, all State colleges and universities in the 17 Southern and border States and the District of Columbia were racially desegregated in practice or in policy by the end of 1965, according to recent figures from the Southern Education Reporting Service. At the elementary and secondary school levels, desegregation was farther from completion, the figures indicate, but 4,804 of the region's 5,372 school districts had submitted plans for desegregation under the Civil Rights Act of 1964 acceptable to the U.S. Office of Education and were considered integrated in principle.

In actual figures, however, only a small number of Negro students at all levels were attending classes with white students in the 11 Southern States. As far as the Service could determine, about 200 Negro students were attending colleges with white students in Alabama. In Mississippi there were no Negroes attending junior colleges with white students, though 16

Negroes were attending formerly all-white State universities. In Florida an estimated 7,612 Negro students were attending junior colleges with white students. About the same number of Negro students were attending colleges with white students in North Carolina. However, the actual number of Negro and white students involved in college desegregation is uncertain, the Service points out, because many States no longer report statistics by race.

At the elementary and secondary levels, the Service reports that actual integration was very slight in the Deep South, but moving toward completion in at least four of the border States and the District of Columbia. Less than 1 percent of the Negroes enrolled in schools in three Southern States—Alabama, Louisiana, and Mississippi—were going to the same schools as white children. Texas had the highest rate for the region—17.2; Tennessee was second with 16.3 percent. In Delaware, the District of Columbia, Kentucky, Missouri, and West Virginia, desegregation was at least 75 percent complete.

A report on figures through November, entitled "Statistical Summary of School Segregation-Desegregation in the Southern and Border States, 1965–66," is available from the Service, Post Office Box 6156, Acklen Station, Nashville, Tenn., 37212. Price: $1.

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"Roundabout," a series of 15-minute television programs aimed at helping disadvantaged, preschool children to understand their environment, went on the air in Washington, D.C., in December 1965. Produced by the educational television station WETA and the United Planning Organization (UPO), the planning agency for Washington's anti-poverty program, the series is being shown in model preschool programs sponsored by UPO and the District of Columbia Public Schools and in church, cooperative, and settlement-house nursery schools. It is financed by a grant of $208,878 from the U.S. Office of Education.

The performers on "Roundabout" are children who live in a depressed area of the city. There is no central figure, though a young man, a kind of big brother or father figure in the script, provides continuity.

Plans call for 104 episodes. Those shown so far have dealt with such topics as modeling with clay, how hinges work, and how a house is put up.

UPO and the Board of Education of the District of Columbia plan to conduct evaluation studies of the films' effectiveness with a selected group of children.

in the journals

Families on AFDC

Arguing for intensified research efforts to discover the true characteristics of families in the program of aid to families with dependent children (AFDC), Henry Miller, in the December 1965 issue of the quarterly *Social Service Review*, maintains that such research has been slight and the results conflicting. ("Characteristics of AFDC Families.")

One study he cites indicates that the incidence of juvenile delinquency is higher among families in the AFDC program, another that it is lower; one study indicates a high rate of alcoholism among AFDC family heads, another that it is lower than in the population as a whole.

Greater knowledge about the characteristics of families in the AFDC program is needed, the author says, as a basis for planning rehabilitation services—but not for justifying the spending of public funds for their maintenance, for this calls only for the knowledge that the fathers are absent or incapacitated and the families poor, and he cites data indicating how poor. He recommends that the research be focused on specific localities rather than generalized, because the characteristics and problems may be different in different places.

Negro families

Challenging the view that there has been a recent rapid deterioration among Negro families, Elizabeth Herzog, in the January 1966 issue of the quarterly *Social Work*, maintains that what is new in the Negro population is "an injection of hope that attacks apathy and fatalism and sparks insistence on full justice." ("Is There a 'Breakdown' of the Negro Family?")

Granting that "fatherless families" are proportionately more prevalent in the Negro than in the white population, the author cites census figures back to 1949 indicating that the rate of broken homes in the Negro population has only gradually increased and not suddenly accelerated. She blames their greater prevalence among Negroes not on a "legacy of slavery" but on "post-slavery factors of deprivation and discrimination affecting every facet of [Negro] life: occupation, education, income, housing, nutrition, health and mortality, social status, self-respect . . . ." The cure, she maintains, is "jobs for Negro men—jobs with status, with stability, with future, and with fair wages."

Suggesting that "the" Negro family is a fiction, Miss Herzog asserts that "different family forms prevail at different class and income levels throughout our society," and cites studies showing a high prevalence of broken homes and illegitimacy among poor white families.

With the warning that "problem-focused discussions" invite distortion, the author points out that even among the poor, two-thirds of the Negro families have the father present. She concludes with the plea that greater attention be given to mobilizing the sources of strength among the Negro poor.

Well-baby clinics

In relation to well-baby clinics "we still stand today on the same threshold which held such promise 30 years ago," Samuel J. Braun, M.D., says in the December 1965 issue of the *American*

Journal of Public Health. ("The Well Baby Clinic: Its Prospects for Building Ego Strength.") There are several fundamental problems that still require solution, he maintains; for instance, how the clinics can reach the many people for whom they are intended, and how to provide continuity of care.

There is little integration in practice of the information gained by the various staff members in well-baby clinics, the author also maintains, even though "common sense" points up the importance of the well-baby clinic to the child's future health and well-being. Much too frequently, he asserts, the public health nurse has carried the responsibility for well-baby care and counseling by herself, "with the exception of the '3-minute' hour contributed by the physician." It is time, he maintains, to support the public health nurse's "valiant singlehanded efforts" and to give her the "wholehearted support of the physician in carrying out the aims and purposes of the well-baby clinic program."

The author maintains that clinic workers have emphasized the one-to-one approach between client and staff members at the expense of a group approach.

Safety first

Preschool children from highly disorganized families, exposed to neglect, extreme and vacillating discipline, and even abuse, develop abilities to cope with their environment at an early age, Charles A. Malone, M.D., maintains in the January 1966 issue of the *American Journal of Orthopsychiatry*. ("Safety First: Comments on the Influence of External Danger in the Lives of Children of Disorganized Families.") However, he adds, these abilities derived from the need to avoid danger are a source of weakness as well as of strength. He bases his conclusions on a study made in a therapeutic nursery school of 21 children from disorganized families living under extreme slum conditions.

The children, the author reports, were quick and agile, but mistrustful. Their conduct at the nursery school reflected guarded fearfulness. At the same time, they showed advanced ability in such tasks as caring for infants and doing simple grocery shopping. But such abilities, the author reports, did not represent "an internal adaptive capacity, but rather a premature coping pattern learned by rote." He found the children bound to external stimuli; their bondage contributing to "rigid literalness" in their learning.

Preschool experiment

In an effort to find out whether the presence of an adult male in a nursery school could help break the "female-dominated environment" of many classrooms, the University Laboratory School, University of Hawaii, placed four boys, seniors at the university's high school, in each of four nursery schools for 45 minutes a day in the first semester of this school year (1965–66). According to a report on the project in the January 1966 issue of *Childhood Education*, the nursery school was selected on the assumption that in it "the preschool child is probably at the best age to benefit from benign male influence...." ("Young Men in a Nursery School," by Will Kyselka.)

At the time the article was written, the author points out, the project was still too new (15 weeks) and too limited for positive results. He reports, however, that the boys were enthusiastic and there seemed to be evidence that the children had benefited.

The article is mainly a report on the experience of the boys who, in addition to keeping daily logs, met with a supervisor from time to time in groups and individually. At first, the boys reported, they felt "awkward and unnatural" though the children paid little attention to them. In a few days, though, they were accepted by the children with whom they romped or read stories to, all within the class routine.

The author says the boys took the assignment very seriously. Said one, "Right now it is a very satisfying experience for me because I'm having fun, but I'd like to know if it is really helping them."

The one-parent child

The child who loses a parent, either by death or divorce, must be helped to overcome his feeling of guilt for not having prevented the loss of the parent, Kurt Freudenthal says in the December 1965 issue of the *Single Parent*. ("The Only Parent.") The child's need for reassurance can be overwhelming, and "it must be met if the child is to grow up with a sense of security and a belief in himself as a worthy person."

The author maintains that it is helpful to a child to keep alive the memory of a deceased parent and of how much the child meant to him. The child cannot be protected, he says, by removing reminders of the dead.

Divorced parents can ease the situation for their child, the author maintains, by continuing to let him know he is loved.

The well-being of the child, he says, also may depend on his maintaining a favorable image of himself and of both parents, particularly of the parent of the same sex. He warns that too close relationships with a single parent, particularly if of the opposite sex, "should be viewed with real concern since they may permanently impair the child's ability to function well in interpersonal relationships."

Welfare law publication

The *Welfare Law Bulletin*, a bimonthly 8-page information bulletin, sponsored by the Project on Social Welfare Law of the New York University School of Law, made its initial appearance in December. According to an announcement in the first issue of the *Bulletin*, it will collect and disseminate information in the field of "welfare law." In addition to brief, signed articles, it will carry notes on court decisions, administrative decisions and regulations, statutes, law review articles, and publications and projects concerning the law and welfare.

The first issue describes the Project on Social Welfare Law of the New York University School of Law and the new Center on Social Welfare Policy and Law at the Columbia University School of Social Work; comments on recent court decisions having a bearing on public welfare administration, including decisions having implications for assistance recipients' right to privacy and for the interstate placement of juveniles; and reviews four new publications on the legal rights of the poor.

The *Bulletin* requests that material on cases pending in courts and administrative offices of public welfare agencies be sent to Mrs. Gertrud Mainzer, Project on Social Welfare Law, New York University School of Law, Washington Square, New York, N.Y., 10003.

BOOK NOTES

LICENSING OF FAMILY HOMES IN CHILD WELFARE: a guide for instructors and trainees. Lela B. Costin and Jennette R. Gruener. Wayne State University Press, Detroit, Mich. 1965. 155 pp. $4.95.

This training guide grew out of a project, supported in part by a Children's Bureau grant, to train college graduates who have had no previous training or experience in social work, for the licensing of independent day-care or full-time foster homes. It is based on the tasks of the licensing worker seen as essential by supervisors and practicing licensing workers who participated in the project. [See pages 63 to 68.]

Presented in the form of a course syllabus, the guide is divided into eight units: (1) licensing—a basic service; (2) statutory basis of licensing; (3) standards and standard formulation; (4) growth and development of the child in the family; (5) the licensing process; (6) differential aspects of family home licensing; (7) community organization aspects of child-care licensing; and (8) the philosophy of licensing. Appendices present and analyze the legal foundations for the licensing standards in Illinois and Texas.

While the guide's chief purpose is to meet the needs of the licensing worker in licensing independent foster family homes, the authors maintain, in the introduction, that it will also be useful in the training of nonprofessional workers for studying family homes sponsored by a social agency.

The authors are both on the faculty of the Jane Addams Graduate School of Social Work, University of Illinois, Urbana.

THE INDIVIDUAL, SOCIETY, AND HEALTH BEHAVIOR. Andie L. Knutson. Russell Sage Foundation, New York. 1965. 533 pp. $6.50.

Primarily a text for schools of public health, medicine, and nursing, this book deals with man as a member of society and his behavior in relation to public health. In the preface, the author, a professor of behavioral sciences at the School of Public Health, University of California, Berkeley, says that he has tried to "unite theory, research, and practice in a way meaningful to the public health practitioner." To this end, he pretested each chapter with "public health colleagues in lectures, seminars, consultations, and discussions," and then added new material.

The book reviews current social-psychological knowledge and theory relating to basic behavior, describes problems of health research, and points out problems needing further investigation. It is divided into sections on the general characteristics of man, man in his social environment, social motivation, human learning and health action, and the communication process.

In a chapter on the "crisis in medical communication," the author maintains that the gap between scientific knowledge and its use grows wider. This, he says, creates "an urgent need to identify, evaluate, and interpret research findings currently available for immediate use in public health practice," and also "to communicate such knowledge effectively in order to elicit improvement in public health behaviors."

READINGS IN CHILD DEVELOPMENT AND PERSONALITY. Edited by Paul H. Mussen, John J. Conger, and Jerome Kagan. Harper & Row, New York. 1965. 480 pp. $4.95.

The 31 contemporary "essays and empirical papers" in this anthology are grouped under six main sections covering biological factors in development during children's early years, early interaction of infants with environment, socialization in the preschool years, early cognitive development, behavioral differentiation (family and social influences), and adolescence.

The volume contains two previously unpublished papers: "Information Processing in the Child" (Kagan) and "Antecedents of Delinquency: Personality, Social Class, and Intelligence" (Conger, Miller, and Walsmith).

The collection is keyed to the major themes discussed in the second edition of an earlier book written by the co-editors, "Child Development and Personality."

THE FAMILY AND INDIVIDUAL DEVELOPMENT. D. W. Winnicott. Basic Books, New York. 1965. 181 pp. $5.

The central topic of "The Family and Individual Development" is "the family, and the development of social groups out of this first natural group." It is a collection of 18 lectures given by the author, child psychiatrist at Paddington Green Children's Hospital in London, mostly to groups of social workers.

The first 11 lectures, grouped as part 1, discuss such topics as the emotional development in the first year of life, growth and development in immaturity, security and the young child, integrative and disruptive factors in family life, the 5-year-old child, the effects of psychotic parents on the emotional development of the child, adolescence, and the family and emotional maturity.

In the lecture on adolescence, subtitled "Struggling through the Doldrums," Dr. Winnicott asserts that nearly all countries today have adolescent groups "making themselves evident in some way or other," and suggests that it might be a sign of a society's health that its teenagers are able to be adolescent at the right time—at puberty. Pointing out that adolescence is a time of personal discovery, he maintains that the adolescent does not want to be understood, and that the only cure for the condition is the passage of time: "Society needs to include this [adolescent doldrums] as a permanent feature and to tolerate it . . . to come to meet it, *but not to cure it.* . . ."

The last seven lectures, grouped as part 2, discuss such topics as advising parents, casework with mentally ill children, deprived children and compensation, and the meaning of the word "democracy."

In regard to democracy, Dr. Winnicott maintains that the best way to promote the democratic tendency is negative action: avoid interfering with the ordinary good home.

READERS' EXCHANGE

GARRETT et al.: *More "exchange" needed*

Many thanks to Beatrice Garrett and to the describers of several innovative programs for their contribution to foster care through the January–February 1966 issue of CHILDREN. ["Meeting the Crisis in Foster Family Care," by Beatrice L. Garrett, and ensuing program descriptions by Mother M. Ann Michaela, Aileen B. Ostazeski, Elizabeth A. Lawder, Vivian Hargrave, and Catherine Pratt.]

More articles like the ones in this group are needed to shake us out of our traditional and inadequate ways of trying to meet the needs in foster family care. One *hears* of new ways of working with groups, interesting experimentation in staff utilization, creative uses of volunteers, consciously planned long-time foster care, agency-owned treatment family homes, subsidized adoptions, auxiliary helps to the foster family, and a variety of methods to give recognition to foster parents as part of the treatment team. These experiences need to be documented, if only in capsule form. Why isn't the Readers' Exchange section of CHILDREN being fully used for sharing what is really going on throughout the country?

The articles, challenging as they were, failed to mention one important point—the cost of some of the innovation. The high per capita cost could very well be the most serious impediment to adopting creative plans. Somehow, we have to get the boards and public budgeters to accept the fact that foster-care costs, like all others, are bound to increase. If anyone has found answers to that money question, the details should be broadcast immediately!

Roman L. Haremski
Deputy Director
Illinois Department of Children and Family Services

Editors' Note: We heartily concur in Mr. Haremski's suggestion that innovators share their experiences with others through this Readers' Exchange, and we hereby broaden the invitation to include not only those in the field of foster care, but in all kinds of services for the health and welfare of children.

POLIER: *Re parental rights*

Justine Wise Polier's thought-provoking article in the November–December 1965 issue of CHILDREN ("The Invisible Legal Rights of the Poor") raises the issue of the termination of parental rights in the case of children in institutional or foster family care whose parents fail to make reasonable plans for the child's return home.

Additional and serious consideration needs to be given to the question of parental rights in respect to the illegitimate child who is placed in foster care practically from birth. In this connection, we need to reconsider our current practice in offering child placement services to the unmarried mother—the only parent in the picture in many foster-care cases. Many unmarried mothers who seek such service are still in their teens and others are very immature. Many are the products of deprived and broken homes. Though unable to provide a home for their infant, they are usually beset by guilt at the idea of giving up the child.

In a praiseworthy attempt to help such a child-woman mature and provide for the infant what mothering she can, all too often the caseworker plays right into the girl's ambivalence and guilt configuration, by helping her to plan for foster care for the infant she is unable to relinquish. In this way, the mother can both hold on to the child by not relinquishing him for adoption and yet effectively give him up, through the more socially acceptable plan of foster care. Of course, both the social worker and the mother continue to hope that she will some day be able to provide the child with a home, but this is a wish-fulfilling fantasy rather than a reality in the great majority of cases.

In this type of case, the infant, if he is lucky, may be placed in some sort of "short-term" foster home. Unfortunately, the infant has no way of conceptualizing such abstractions, and cannot distinguish "short-term" from "long-term." When, therefore, it becomes obvious somewhere in the child's second year, or later, that he is going to need foster care for an extended period of time, and a replacement is made, he is unable to comprehend the grown-up logic of the change, and must feel as though his world has been shattered, which indeed it has been.

Because of factors encompassing both the threat to the child's feeling of security, closely tied up with the first foster "mother," and the immense potential this "mother" has at this point for socializing the child, it seems to me that there is no such thing as a "good" short-term plan for an infant, and that such a plan should only be resorted to under extreme circumstances, and never as a matter of almost routine policy as in the case of illegitimate children.

I am not overlooking the fact that we are dealing with an area of great social concern in which changes are difficult to make and may have far-reaching effects. There has been a natural and deeply rooted reluctance to tamper with the rights of natural parents, in this case the natural mother. However, we are dealing here not with "natural rights" in the original meaning, but rather with a fringe area of parental rights in part created through the very provision of foster-care services, which have made possible the assumption of rights without the assumption of any responsibility for the care of the child.

In this area, as in many others, inaction is really a positive act. Our continued unwillingness to face the issues and take a stand has immense repercussions for children in foster care.

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JUVENILE DELINQUENCY—FACTS, FACETS: the institutional care and treatment of older hyperaggressive delinquent children. George H. Weber and Raymond L. Manella. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. No. 19. 1965. 9 pp. 15 cents.

This 19th document in the Children's Bureau series on juvenile delinquency discusses the problems faced by institutional and State agency administrators in legal, administrative, facility, and program planning for extremely aggressive older delinquents who do not respond to the basic patterns of institutional care and treatment. It cites factors which in recent years have intensified the difficulties in the task of treatment and rehabilitation, among them, the greater hostility in children admitted to institutions.

JUVENILE DELINQUENCY PREVENTION IN THE UNITED STATES; and THE CONTROL AND TREATMENT OF JUVENILE DELINQUENCY IN THE UNITED STATES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1965. 60 pp.; 36 pp., respectively. Single copies available from the Bureau without charge.

Two reports prepared for the Third United Nations Congress on the Prevention of Crime and Treatment of Offenders, held in Stockholm, Sweden, August 9–18, 1965. The first discusses the social forces behind the expanding juvenile delinquency problem in the United States and describes the interrelated efforts of Federal, State, and local agencies to develop and refine comprehensive preventive programs, with special emphasis on programs established under Federal legislation enacted since 1961.

The second report discusses the roles of police, detention care, probation services, group treatment programs, camps, and parole supervision in the control and treatment of delinquency.

CHILD WELFARE STATISTICS—1964. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Statistical Series No. 82. 1965. 45 pp. Single copies available from the Bureau without charge.

Through 40 tables and text this publication presents 1964 statistics for individual States and the country as a whole on children receiving various types of child welfare services from public and voluntary agencies and institutions, licensed day-care facilities, and children provided care in such facilities; public child welfare agency personnel and salaries, and personnel granted educational leave; expenditures from Federal, State, and local sources for public child welfare services; and 1963 statistics on children for whom adoption petitions were granted.

It points out that of the 652,000 children who were receiving child welfare services on March 31, 1964—5 percent more than on the same date in 1963—68 percent were being served primarily by public agencies or institutions. Two-fifths of the total number were living with parents or relatives; nearly one-half were in foster care; and one-tenth were in adoptive homes.

SERVICES FOR CHILDREN: How title V of the Social Security Act benefits children. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Fact Sheet. Revised 1965. 16 pp. Single copies available from the Bureau without charge.

Written in question and answer form, this pamphlet describes the nature and purposes of grant programs administered by the Children's Bureau under the Social Security Act to provide for maternal and child health services, services for crippled children, child welfare services, and demonstrations and research relating to such services.

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